SURVEY OF PROGRAMS
for the
DEVELOPMENTALLY DISABLED
IN MINNESOTA

Prepared for the
EXECUTIVE OFFICE OF THE GOVERNOR
STATE OF MINNESOTA

By the
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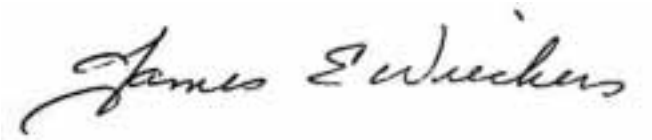
Approved for INSTITUTE FOR
INTERDISCIPLINARY STUDIES



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FOREWORD

The Office of the Governor is currently implementing a state plan under P.L. 91-517, the Federal Developmental Disabilities Services and Facilities Construction Act. One requirement of the Act is that a State Planning and Advisory Council be established to "...set the pace for the direction, development and growth of the program...."

Minnesota's Council has been formed and has held its initial meeting. Governor Wendell Anderson's aide, W. Dennis Pederson, has anticipated that the Council would require background information concerning activities related to developmental disabilities that have been carried out by state and private agencies both before and since the enactment of P.L. 91-517.

The Institute for Interdisciplinary Studies (IIS) was asked on November 8, 1971, to act as an extension of Mr. Pederson's staff to obtain several kinds of information within Minnesota and from neighboring states. Specifically, IIS has:

1. Through coordination with the Office of the Governor, developed a structured set of questions to be used in interviews with persons in state agencies working with individuals eligible for assistance under the definitions of the developmental disabilities act. The general areas explored by the questions included:
   - agency structure,
   - descriptions of programs related to developmental disabilities,
   - information and referral practices,
   - agency planning techniques,
   - agency advocacy practices,

- agency interaction with other state groups and the private sector, and
- agency suggestions of areas of consideration by the Council.

2. Developed a similar set of questions to be used in inter views with private organizations.

3. Reviewed current literature on use of advocacy programs related to developmental disabilities and on use of information to develop priorities of need within communities.

4. Called directors of developmental disabilities programs in Nebraska, Pennsylvania, Ohio, Wisconsin, and Kansas to determine how they were developing priorities and advocacy programs. These telephone contacts led to other persons within the states who were involved in developmental disabilities programs.

5. Developed a bibliography of pertinent information on developmental disabilities which can be used by the Council.

6. Conducted interviews with both state and private agencies and organizations in Minnesota using the structured sets of questions described above.

The direct interviews were carried out in a variety of settings. In some cases a single person represented an agency; in other instances a staff was interviewed as a group. Some agencies suggested several persons who were interviewed individually. All of the persons and agencies were fully cooperative and spent considerable time in attempting to provide information for the project.

Three IIS reports summarize the findings of the study, comment on the perceptions of the IIS staff about the quality of the information obtained, and recommend other areas which the Council may

consider to investigate. These three reports are entitled:

1. Survey of Programs for the Developmentally Disabled in Minnesota.
2. Advocacy Programs for the Developmentally Disabled - A Five-State Survey.
3. Developmental Disability Plans - A Five-State Survey.

Reports number two and three are bound together under the joint title, Developmental Disabilities: Advocacy Programs and State Plans - A Five-State Survey.

SUMMARY

This report presents the results of interviews with the public and private agencies and organizations in Minnesota listed below. The list was developed by the Governor's office to include those agencies and organizations that are statewide in the scope of their activities and that are involved in providing services to or planning for developmentally disabled individuals.

- Department of Public Welfare;
- Department of Health;
- Department of Education;
- Department of Manpower Services;
- Department of Corrections;
- State Planning Agency;
- Governor's Commission on Employment of Handicapped Persons;
- Minnesota Advisory Board for Handicapped, Gifted, and Exceptional Children;
- Minnesota Association for Retarded Children;
- United Cerebral Palsy of Minnesota;
- Minnesota Epilepsy League;
- Minnesota Rehabilitation Association;
- Minnesota Association of Rehabilitation Facilities;
- Minnesota Administrators of Special Education;
- Minnesota Association of Mental Health and Mental Retardation Programs;
- Mental Health Association of Minnesota

The programs of each of these agencies and organizations that are related to developmental disabilities are described in this report. Interpretive material shows their interrelationships and gives special emphasis to information-gathering, planning, and advocacy activities. Suggestions and comments for the Planning and Advisory Council are also presented in the paper.

Recommendations have been made in the areas of (a) Advisory Council organization and planning, (b) coordination of state-level planning and priority setting, and coordination of services to individuals, (c) regionalization, (d) determination of needs through the use of statistical indicators and the development of a registry of the developmentally disabled, (e) prevention, (f) preschool services, and (g) advocacy. Following is a brief summary of the information to be found in each chapter.

Chapter 1, "Administration Relationships and Responsibilities," describes the relationships among the governmental agencies and advisory groups; this chapter also gives brief descriptions of the responsibilities of each. Organizational charts show the location within departments of those programs that serve the developmentally disabled. The number and range of these programs is considerable. The recently organized Retardation Services Division in the Department of Welfare has responsibility for several, but not all, programs and agencies providing services. Currently, there is no centralized locus of authority or means for coordinating the planning of these diverse programs and agencies.

Chapter 2, "Regional Structures for Services and Planning" discuses the ways in which each agency divides the state into regions for purposes of planning and providing services. Maps are provided illustrating the similarities and differences of boundaries used. Included in this chapter is a map showing population and poverty areas, based on 1960 census figures, and a ranking of counties by percent of persons with incomes less than $3,000 per year.

Chapter 3, "Programs for the Developmentally Disabled," describes each program operated by the groups included in the survey. An overview of these dozens of programs is provided in a table of the estimated numbers of developmentally disabled persons now being served by each program each year and a table showing the amounts of federal, state, and other funding for these programs.

Details are provided for the programs on their objectives, planning process, the numbers and characteristics of people served, services provided, results obtained, staffing, budget information, and projections on possible program changes if additional money were available.

Information in this chapter is drawn upon for specific consideration in subsequent chapters.

Chapter 4, "Information, Referral and Advocacy Services," describes these specific services as they are currently being provided in each program. Where the information was available, the volume and estimates of the effect of these services is also given. The unmet advocacy needs of the developmentally disabled, as viewed by the agency and organization representatives interviewed, are also presented. There was a consensus of opinion that additional, individual advocacy mechanisms are needed.

A description of advocacy services for developmentally disabled individuals in several other states is provided in the report Advocacy Programs for the Developmentally Disabled - A Five State Survey.

Chapter 5, "Interaction Among Agencies and Organizations," summarizes, displays, and evaluates the interaction of each agency and organization covered in the survey with the others. Varied interpretations of what constitutes different levels of interaction made conclusions difficult to draw. There was, however, general agreement on the need to develop mechanisms for strengthening interactions.

Chapter 6, "Planning and the Use of Information," summarizes the nature of planning for the developmentally disabled and discusses the ways in which various kinds of information are now used for identifying needs. Most of the current planning effort in the state agencies is in response to specific requests or for meeting requirements for funding, rather than in response to an estimate of overall needs. Most agencies use rough estimates of incidence of categories of disabilities. There is no centralization of information, no means of combining or comparing existing information, almost and little joint planning.

Potential sources of information are described both for identifying individual developmentally disabled individuals needing services and for estimating incidence and prevalence, particularly for geographic areas where needs may be expected to the greatest,

Chapter 7, "Agency Comments," is a summary of the views of the agency and organizational representatives interviewed in this survey in the areas of (a) major problems in the network of services to the developmentally disabled, (b) gaps in services, and (c) Advisory Council objectives and functions.

RECOMMENDATIONS

In view of the limited resources available to the Council, particularly for the delivery of services, the Council will need to select its areas of concentration carefully to maximize impact on the system of services to developmentally disabled persons.

The Council might therefore consider focusing its attention less on funding for specific service programs and more for such issues as coordination of planning, regionalization, identification of major system defects, personal advocacy, stimulating the modification of existing programs, and re-allocation of existing resources to maximize their impact.

The recommendations that follow were derived largely from the information, comments and suggestions obtained in the survey of agencies and other organizations. They are grouped by subject and are not listed in any order of priority. While it will not be possible for the Council to take action on all of these recommendations within fiscal year 1972, it is urged that they be carefully considered in subsequent planning.

Council Organization and Planning

The need for information The Council may wish to survey programs and planning at the local and regional levels in a manner similar to this survey at the state level. There are considerably more data available on needs, services, and results at the local service level that are available at the state level. The private agencies and the institutional programs throughout the state are only briefly covered

in this report. The Council may need additional information on such private resources as capacity, services provided, costs, and sources of funding.

Such a survey could also help the Council determine potential for regionalization. Direct contact could best assess the capacity and readiness of existing resources for planning and coordination.

Approach to Developmental Disabilities A major issue, basic to the planning of the Council, will be deciding either to (a) hold to the specific diagnostic categories defined in the legislation and organize plans around these, or (b) encourage programs which serve the developmentally disabled according to clients present and potential functional levels, regardless of diagnostic labels. This latter, behavioral or functional view of disabilities probably holds the greatest potential for the Council in its role of coordinating resources and identifying and filling the service needs of people. In order to promote use of this approach, the Council could consider requiring all projects funded under Developmental Disabilities legislation to use a behavioral approach in both assessing and providing services.

Goal specification The goals of most agencies and organizations are now largely determined by specific federal and state legislation and funding mechanisms. However, goals are very rarely stated in quantitative terms. This makes evaluation virtually impossible. Most programs state their objectives in terms of general services provided rather than defining who will be served and what specific, concrete objectives will be achieved. The Council should provide guidelines for the projects it will fund in terms of specific objectives and built-in evaluation procedures.

Information dissemination

The council should disseminate reports of its findings, plans, and actions to groups and individuals concerned about the developmentally disabled. Most of the governmental agencies and private organizations have regular newsletters distributed among their staffs or members. Reports from the council included in these newsletters would reach virtually all professionals serving the developmentally disabled and other concerned citizens.

Coordination

Virtually all departments and agencies contacted in this survey indicated that they look to this Council as a potential coordinating mechanism, which they feel is very much needed. There are many well-established vehicles for communication among departments, agencies, and organizations; but means for coordinating, planning, and setting top-level objectives and priorities are inadequate.

Planning for the individual

Early diagnosis was cited as a significant need by most persons interviewed At the same time, there was an equally strong reaction against "labeling." It is assumed that the Council will consider behavioral function levels as a basis for assessment and will include a requirement for an individualized care or service plan as a necessary follow-up to adequate diagnosis.

Coordinated planning for each developmentally disabled individual means a comprehensive evaluation of abilities as well as deficits. Goals and service plans must be developed to meet total needs. not just those met by a single agency. These plans must be updated regularly and should provide for a continuum of coordinated services as long as they are needed.

Two major potential resources for such diagnostic services on the regional level appear to be the network of 25 community mental-health, mental-retardation, inebriacy boards, which already have most of the diagnostic team available, and the state-operated institutional centers. A few of the centers are already moving in this direction. The Council may want to provide further impetus to these efforts.

The many agencies and departments serving developmentally disabled people use a wide range of diagnostic scales, systems, and tools. The Council should consider defining acceptable guidelines, and standards for evaluation to be used by the public and private sectors. Such standards could include: (a) when various diagnostic procedures should be used, (b) what diagnostic procedures should be used, and (c) what constitutes adequate diagnosis.

Public - private interaction — The roles and responsibilities of the public sector have never been clearly defined. The Council may want to identify where the major strengths of each exist in a comprehensive system and build upon them. For example, there was general agreement among those interviewed that two of the most effective organizations in the area of advocacy are Alcoholics Anonymous and the Association for Retarded Children, both private operations. There was equal agreement that state agencies have a greater capacity for implementing large scale programs than do most private organizations.

Referral procedures — There is a complex array of public and private agencies and programs serving the developmentally disabled. The survey revealed that the present cross-referral system is not thorough. Most of the departments and private

organizations appear to refer individuals for single services or to single agencies. There is no apparent mechanism, on a state department level, to assess the client's total needs and to review available resources outside a department's domain. Follow-up of referral appears to be scanty and irregular.

The Council should consider defining an optimal referral procedure that would ensure that the problems of persons are identified and referred for whatever services are needed, regardless of which agency or program is serving them. Clarifying referral policies and procedures — and developing a mechanism for monitoring referrals -- would help bring about better utilization of current resources and help identify significant gaps in the network of services.

Legislation The Council may want to request a more detailed review of the federal and state legislation that is related to services for developmentally disabled people. Such a review should cover legislation applying to all public and private resources, and should particularly address restrictions imposed by each and identify the overlaps and potential conflicts generated by all. Legislative restriction of funding and criteria for eligibility should be clearly summarized, and legislative needs should be identified.

Financial information Cost of programs and services are calculated differently among, and often within, departments. This makes comparisons or even summaries of budgets misleading. A department may know how much federal and state money it directly spends, but may not know other indirect costs or the costs incurred by other departments or the local community in operating the program.

There is no single source of information on various federal monies coming into Minnesota to support programs for developmentally-disabled. The Planning Agency has been unable to retrieve more, than a partial list of this information from its computer.

Recent efforts within some departments to begin program budgeting should reduce these problems somewhat. The Council should be supportive of all efforts that will lead to more useful financial [information for planning and program-evaluation purposes.

Regionalization The report graphically shows the many differences in the regional boundaries used by various departments and programs, both for planning and the provision of services. The council will need to determine its goal for regionalization and consider various methods of encouraging efforts to resolve these conflicting systems and and develop as great a degree of uniformity as possible.

In determining appropriate existing bodies to be used for regional planning, the council should develop guidelines for their operation and particularly for their interrelations with other planning and coordinating bodies in the area. The use of such guidelines would probably result in different groups being assigned this responsi-bility in different regions, because of their varying capabilities and readiness to assume this role.

Determination of Need

This survey and a review of earlier Minnesota projects and studies fai1ed to reveal any adequate information on the incidence of developmental disabilities among the disabled persons within the state.

Definitions are imprecise and underlying assumptions are rarely specified. However, this lack of precision in determining the numbers of developmentally disabled persons is not considered to be, by itself, a significant problem. What is needed is better information about persons who are currently not being served, their numbers, and their service needs.

Selected surveys of need — The planning and Advisory Council should consider the value of sponsoring surveys of existing need. Such surveys could be conducted in small rural, urban-poverty, and other areas known to have the fewest available services. The relations among poverty, greater incidence of mental retardation, and less-available services is becoming more evident. The incidence of retardation ranges from less than 1% in areas of relatively high income and adult-educational levels to more than 3% in areas of low income and educational levels.

Such high-incidence areas could be identified by measuring a variety of indicators:

- percent of families with annual incomes below $3,000;
- median adult education level;
- infant mortality rates;
- percent or number of identified "high-risk" mothers and infants, (according to Health criteria);
- rate of usage of residential institutions for the retarded; and
- estimates of people not being served by existing resources.

Registry — The Council should consider the value and means of developing either a statewide or regionally based registry of developmentally disabled persons. Such a centralized

Advocacy

There is little advocacy for individuals in Minnesota, in contrast to the extent of program advocacy. Most individual advocacy efforts are in the private sector, although there are two new programs in the public sector. The Department of Welfare is setting up public information offices to handle complaints about services, and the Departments of Education and Corrections are setting up Youth Advocacy programs to help young people in Minneapolis and Duluth returning to schools from correctional institutions.

Council considerations may well be directed toward defining the types of advocacy programs that are needed and the mechanisms necessary to establish them. Individual advocacy should not be instituted on a large scale until there is a clear understanding of the type and extent of resources needed to handle a large volume of individual requests for assistance. The Council may consider supporting one or more demonstration projects of limited scope in the area of individual advocacy. Such projects should contain adequate plans for documenting their development and for evaluating their results.

Chapter 1. ADMINISTRATIVE RELATIONSHIPS AND RESPONSIBILITIES

The Institute for Interdisciplinary Studies interviewed persons in a large number of organizations within Minnesota. Organization charts (Figures 1-6) show the administrative relationships among these advisory bodies, planning agencies, and state departments. Only those subdivisions are shown whose activities are directly related to the developmentally disabled. The departments and their program responsibilities related to developmental disabilities are described briefly. Details of each program are given in the following chapter.

1.1 The State Planning Agency

This agency consists of the Governor as State Planning Officer, a director of planning, and other personnel deemed necessary to discharge the state planning function. The agency is charged with responsibility for developing long-range plans and programs for the orderly growth of state government. It is also a coordinative agency for planning activities of state departments and local levels of government.

In addition, the State Planning Agency has responsibility, under the State Planning Act, to "act as a directing, advisory, consulting, coordinating agency to harmonize activities at all units of governmental units, to stimulate public interest and participation in the development of the state."

Comprehensive Health Planning

One of the functions assigned to the State Planning Agency is

Comprehensive Health Planning. This assignment is in fulfillment of requirements established under P.L. 89-749 and as amended by P.L. 90-174 and P.L. 91-515. This legislation established a statewide planning process with the ultimate mission of "promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living...."

The State Planning Act was designed to stimulate state, interagency, and area wide health planning through the development of a partnership between the citizens who use health services, the professionals who provide health services, and representatives of local government.

An advisory council, with a majority of representatives of consumers of health services, advises the program on the development and implementation of comprehensive health planning in the state. Council members are appointed by the State Planning Agency with the approval of the Governor's Office.

Among the planning functions accomplished by this program are several related to the developmentally disabled in this state. "A Policies Plan for Residential *Care,"1968, recommended the* development of multi-purpose regional centers from the single-purpose institutions for the mentally ill or retarded. This plan endorsed the concept of community-based treatment for the mentally ill, mentally retarded, "inebriate,"* and aged individuals.

As a follow-up to that report, the Public Welfare Facilities Committee in 1970 developed a report, which became known as the "Hoffman Report." The Hoffman Report projected the potential population for state residential-care facilities and the usable space in each facility for both living and program requirements, and made specific recommendations as to the utilization of each facility for a five-year period.

*See page 8 for definition.

STATE-LEVEL RELATIONSHIPS OF ORGANIZATIONS
INVOLVED WITH DEVELOPMENTAL DISABILITIES

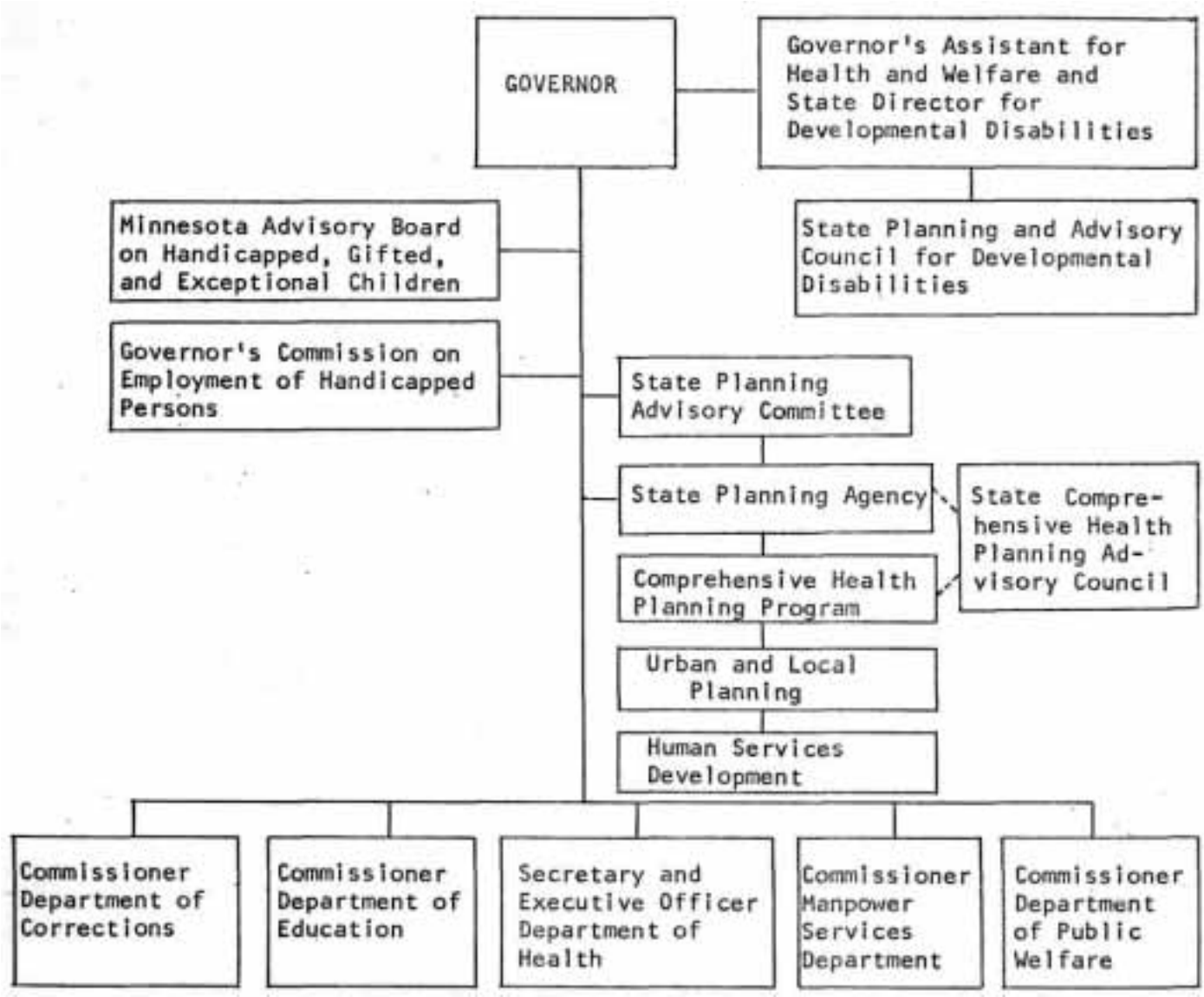


Figure 1

The next and latest related activity in this sequence is the development of the "Behavioral Disabilities Report and Recommendations." which is awaiting approval and shall be released shortly. This report was developed by the Comprehensive Health Planning Program and the newly-created Office of Planning, Department of Public Welfare; in conjunction with a task force of the State Comprehensive Health Planning Council.

Behavioral disabilities are defined in the Behavioral Disabilities Report as behavior judged unacceptable to an individual himself, or to his. family, his community, or general society. Behavioral disabilities may have biological and organic sources, psychological sources (childhood training and parental influences), or may spring from external stress, social stress, or volitional acts.

Major recommendations are to:

1. Reduce the role of the state Department of Welfare in provision of direct services to individuals.

2. Place increased emphasis on planning for behavioral disabilities at the regional level and make maximum use of existing regional organizations and agencies.

3. Develop a workable system of community-based responsibility for development of such programs at a regional or area wide level.

4. Implement a program to ensure that continued planning will take place, including the following responsibilities:
   - determining the nature and extent of the problems of behavioral disabilities in the region involved;
   - designing a region-wide system to ensure a continuum of care, in conjunction with other appropriate regional, county, area wide planning agencies and providers of service;
   - maintaining coordination and communication among those agencies and systems in the region responsible for dealing with behavioral and developmental disabilities;

- examining, in cooperation with appropriate state agencies, the nature, role and function of state residential care facilities or other "backup" residential care services for all disability groups, including state hospitals and regional detention centers.

5. Identify and remove laws that stigmatize and label persons for acts that do not harm other persons or property.

6. Give private agencies more responsibility for developing and implementing an advocacy system for behaviorally disabled individuals.

Urban and Local Planning

The Urban and Local Planning responsible for administering the Regional Development Act, which provides for planning and development of programs for the solution of economic, social, physical, and governmental problems within the state. Administration is effected in each of the state planning regions through creation of regional commissions, composed of members of county boards, town boards, city governments, school boards, and citizens representing public interests. Each commission selects its own officers. Commission members serve without salary, but are allowed per diem and expense allowances.

The State Planning Agency coordinates and facilitates commission planning and development. The regional commission receives state and federal grants; prepares and adopts a comprehensive development plan for the planning region in cooperation with county and municipal plans; contracts for services of local governments; engages in planning research; and reports annually to levels of government and the public within the region, the legislature, and the Governor.

Funding, not to exceed $25,000 per fiscal year, is made available by the State Planning Officer to each commission. In addition, grants and gifts are accepted, and the regional commission may levy a property tax in the region.

Human Resources Planning

The office was essentially new in 1971, replacing some of the functions of the previous Social Resources Planning unit, and assuming additional responsibilities related to state health manpower. Planning involves activities of the government that contribute to the development of individuals and to the state manpower resources. Human Resources Planning coordinates their efforts with the Departments of Education and Manpower Service.

1.2 The Commissioner of Public Welfare

The Commissioner of Public Welfare is appointed by the Governor. His department (Figure 2) has been made responsible by the legislature for the prevention and treatment of a vast number of social ills and problems. Among them are medical care for the medically indigent under 21 or over 65 years old and persons receiving public assistance under the Old Age Assistance, Aid to the Disabled, Aid to the Blind, and Aid to Families with Dependent Children programs. Next in number of cases is mental illness and mental retardation, followed by the problems of caring for children who have been separated from their parents, or who are neglected, illegitimate, or mentally deficient.

Four of the seven divisions and the Office of Planning have some kind of responsibility for services covered by the Developmental Disability legislation. They are the divisions of Social Services, Rehabilitation Services, Medical Services, and the Retardation' Services Division.

DEPARTMENT OF WELFARE

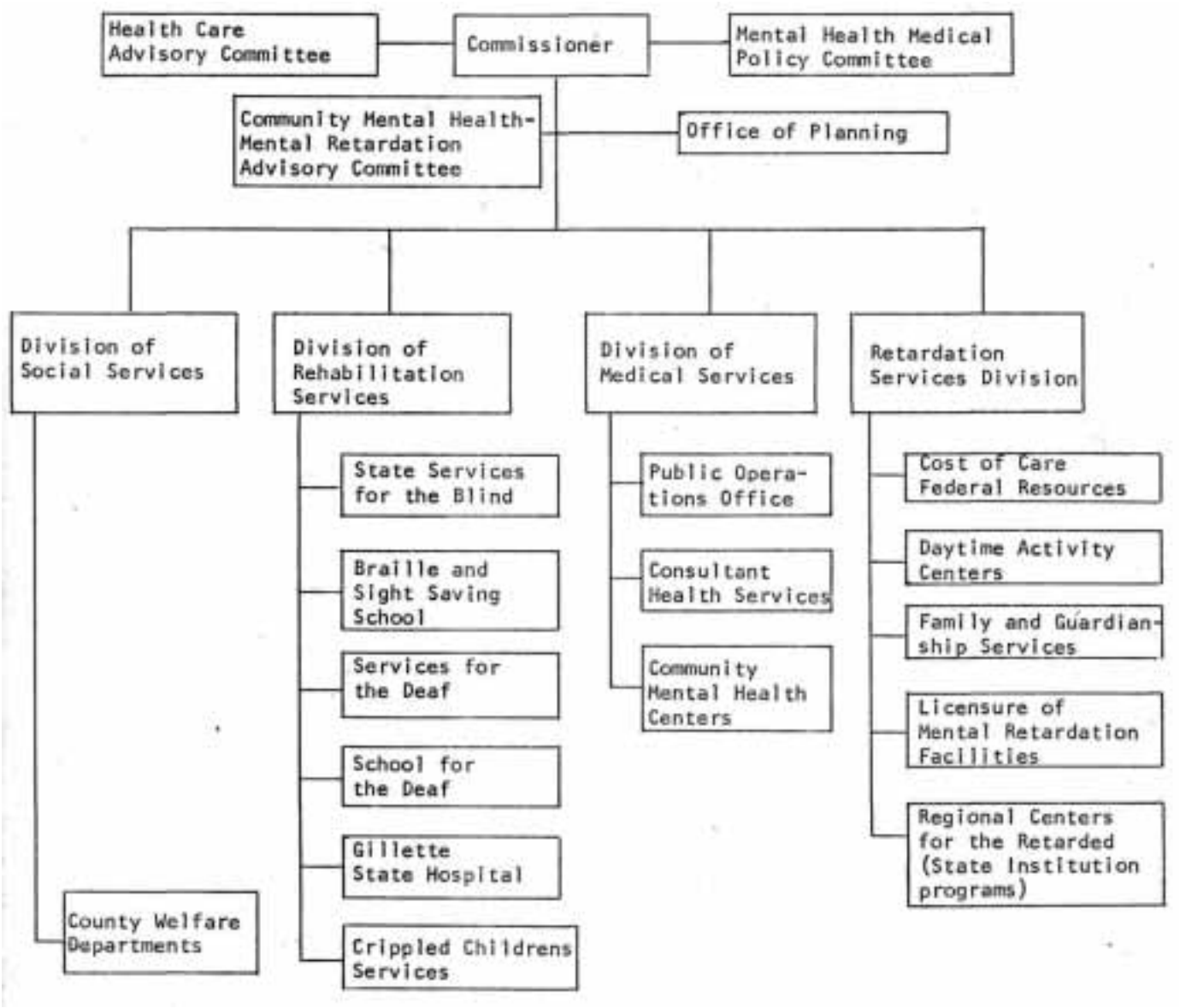


Figure 2

The Social Services Division

The division of Social Services was the Child Welfare Division until the 1971 Legislature reorganized it to include adults as well. The program now serves the blind, aged, and disabled persons of all ages.

The division director is also responsible for the Head Start Program for disadvantaged children (Health, Education, and Welfare contract) and for licensing voluntary agencies and institutions, day-care facilities, and foster-care facilities.

The functions of the division are supervision and coordination, technical assistance to county welfare departments, and evaluation. The objective of the state supervisory and county service elements of the program is to identify, treat, and prevent problems of neglect, illegitimacy, delinquency, and educational and social breakdowns that tend to accompany mental and physical difficulties.

Evaluation involves monitoring service plan performance of local administrative units, as well as collecting and distributing information on performance to other divisions of the Department of Welfare and to local administrative units.

Programs for developmentally disabled persons are state-supervised and county-administered. Program direction and content is set by Department of Public Welfare divisions of Rehabilitation, Medical Services, and Retardation Services and Social Services. Each division has its specific responsibility defined in terms of the disability (mentally ill, retarded, inebriate,* etc.) or in terms of areas of service.

Statistical information concerning the operation of the program

*"Inebriacy" or "inebriety" is a generic term that is used to signify habitual and harmful use of, or dependency upon, any chemical intoxicant. See pages 60-63 for further, brief discussion.

is sent to the Division of Rehabilitation, the Medical Services and the Retardation Services Divisions. Policies are coordinated within the department and with other departments.

Service to individuals is provided through the 87 county welfare departments. Administration of the departments is by county welfare boards selected from their own service areas and regulated by Minnesota statutes.

The Rehabilitation Services Division

The division of Rehabilitation Services draws together the Departments' responsibilities for the deaf, the blind, and otherwise physically handicapped persons. The division includes: Crippled Children's Services, Gillette State Hospital, Services for the Blind, Minnesota Braille and Sight-Saving School, Services for the Deaf, and the School for the Deaf.

The Medical Services Division

The division of Medical Services has administrative responsibility for the treatment and rehabilitation programs for the mentally ill and inebriate in the state-hospitals, and for administration of the Department of Public Welfare grant-in-aid program to community mental-health, mental-retardation, and inebriacy program boards. This responsibility includes education and consultation.

The program's components form a network of services linking the hospital programs for the mentally ill and inebriate with the community. The hospitals serve as care and treatment resources to residents of counties in their specific receiving districts. They also share responsibility with the counties' area mental-health, mental-retardation programs and with other community groups in planning and carrying out a comprehensive program within their particular regions of the state. The county welfare departments provide direct family and social services, including

mental-health services, and also participate in local program development. The area mental-health and mental-retardation programs provide both direct and consultative services, and also have the responsibility for planning, developing, implementing, and evaluating a total area-wide program to reduce the incidence of specific mental-health and mental-retardation problems.

The Retardation Services Division

The division of Retardation Services was created by the 1971 Legislature. The Commissioner of Public Welfare previously had legal authority to act in behalf of any retarded person who needed care, supervision, protection, or training. That legal responsibility and authority was transferred to the Retardation Division at the time of its creation. The Retardation Division works with and through the other divisions of the Department of Public Welfare — in the supervision of all county welfare departments in the state (Social Services Division), administration of the Community Mental Health-Mental Retardation Programs (Medical Services Division), budget preparation and administration (Administrative Services Division), and overall administration of state institutions for the mentally ill, mentally retarded, and alcoholic. (Responsibility is between Retardation Services Division and Medical Services Division.) The Retardation Services Division is responsible for the planning, development, administration, monitoring, and evaluation of the programs of the Department of Public Welfare for the mentally retarded. (A preliminary draft of the DPW plan for the retarded has been sent to members of the Council.) Services and programs for the retarded are carried out in a variety of ways: by direct supervision of state institution programs; by grants-in-aid to day-activity centers; by grants-in-aid to community

mental health, mental retardation boards (Medical Services Division); by administration of cost-of-care reimbursement to counties for placement in communities; by supervision of family and guardianship services; by liaison with private facility operators and administration of the Mental Retardation Licensing Act.

The Retardation Services Division also works closely with the Department of Education and Health in behalf of the retarded individual.

Office of Planning

The planning program was created when the 1971 Legislature assigned the responsibility for developing a comprehensive plan and making recommendations for a total system of state institutions and community centers to the Commissioner of Public Welfare. Goals, objectives, and functions of state institutions and community health programs are to be integrated so that they operate as a community-based system that allows individuals to be treated for mental illness, mental retardation, or inebriety in their own communities.

1.3 The State Board of Health

The Board of Health (Figure 3) is composed of nine members appointed by the Governor for three-year, overlapping terms. The Secretary and Executive Officer is elected by the Board and serves as state health officer. He is responsible to see that rules and orders of the Board and all duties given it by law are enforced and performed, and that laws enacted in the interests of human health are obeyed.

The Maternal and Child Health Section

The Maternal and Child Health Section, under the division of

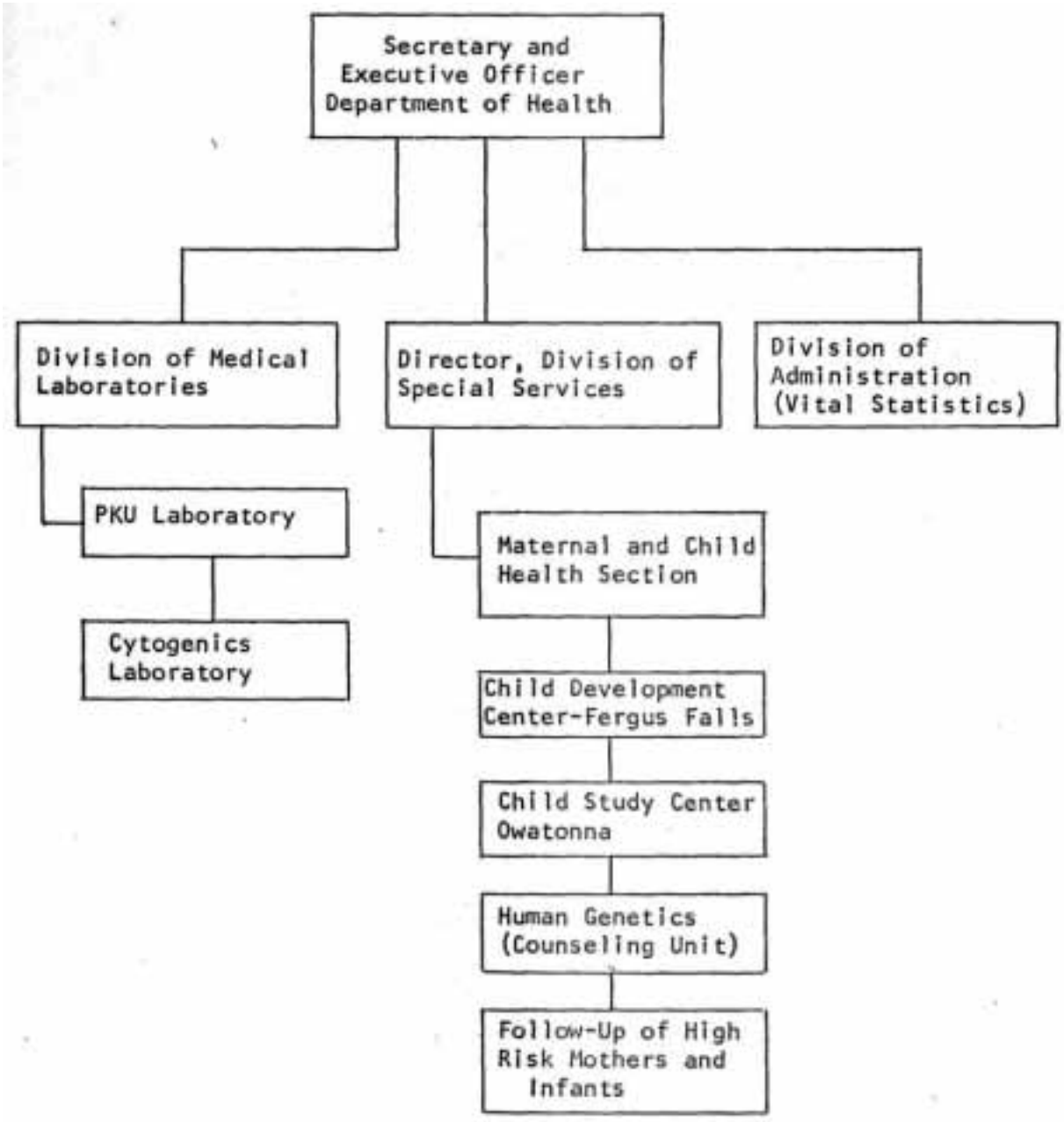

Secretary and Executive Officer Department of Health
Division of Medical Laboratories
Director, Division of Special Services
Division of Administration (Vital Statistics)
PKU Laboratory
Cytogenics Laboratory
Maternal and Child Health Section
Child Development Center-Fergus Falls
Child Study Center Owatonna
Human Genetics (Counseling Unit)
Follow-Up of High Risk Mothers and Infants

Figure 3

Special Services, provides medical and nursing consultation, and assistance in developing maternal- and child-health programs, including nutrition, human genetic counseling, accident and poison prevention, and school health. Since 1957 it has carried out a program designed to stimulate community interest in the development of facilities and services in rural areas to meet the needs of the handicapped. Two examples are the Child-Development Centers at Fergus Falls and Owatonna. These centers are cosponsored with the Minnesota Department of Public Welfare and work in close cooperation with the Minnesota Department of Education.

The Division of Medical Laboratories

The division of Medical Laboratories operates two programs relevant to developmental disabilities. The P.K.U. Laboratory Service Program runs tests on. all newborn infants in the state to determine certain metabolic anomalies. The Cytogenics Laboratory provides chromosome analysis to identify chromosomal anomalies, including those related to forms of mental retardation.

1.4 The Department of Education

The Department of Education is administered by the Board of Education, which is appointed by the Governor (one member from each of the eight congressional districts and one at large). The board elects the commissioner.

Activities in all four divisions (Figure 4) are related to educational services for the developmentally disabled.

The Division of Vocational-Technical Education

The division of Vocational-Technical Education is in the process of developing new plans. At present there are 33 vocational-

DEPARTMENT OF EDUCATION

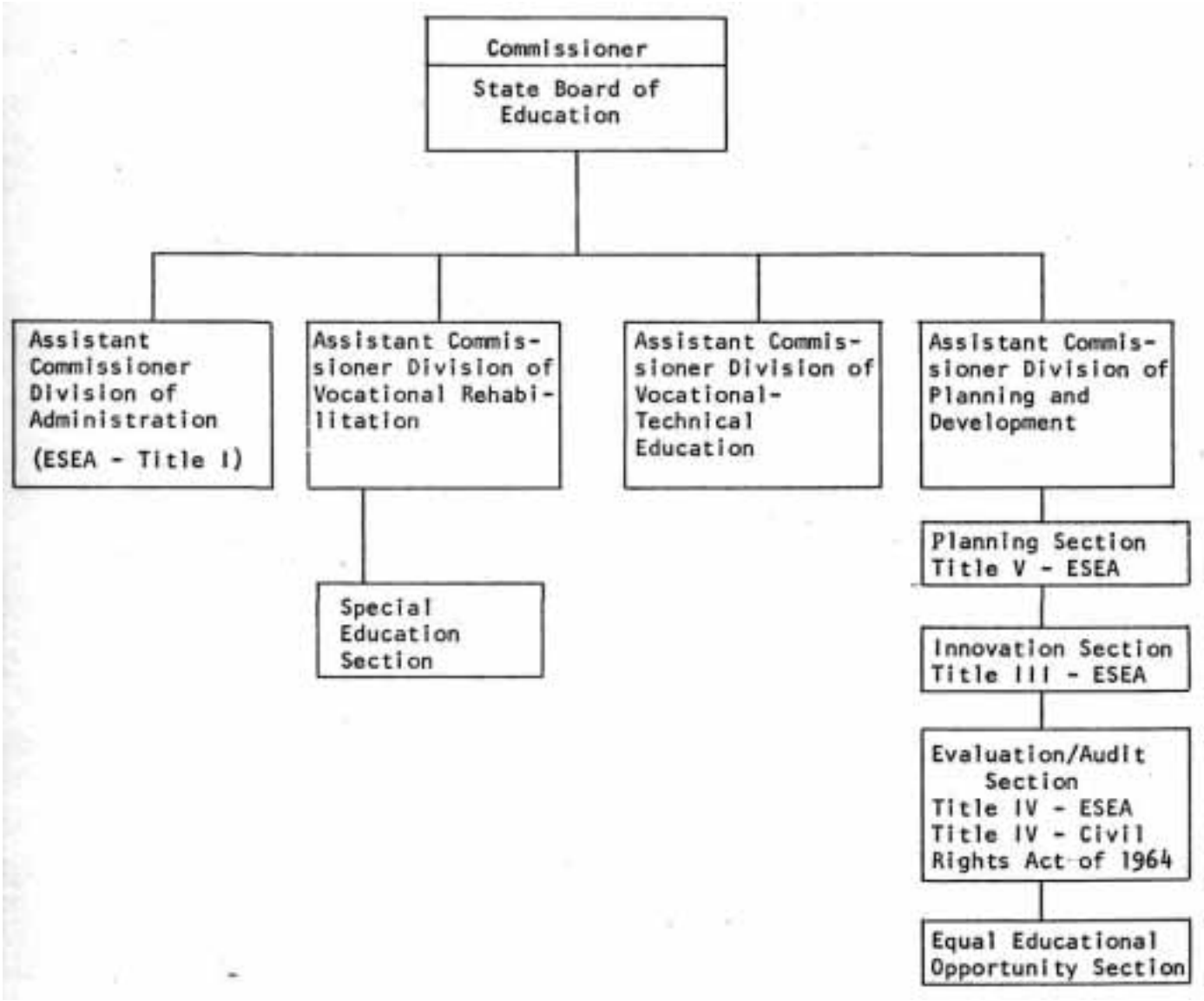


Figure 4

technical schools in Minnesota that offer specific skill-training programs and in-service and upgrading courses; these services are free to persons under 21 and returning servicemen and are offered at nominal cost to adults. The department works closely with the Department of Manpower Services to provide relevant education in occupations where employment opportunity exists and expansion is anticipated. Services are coordinated with the Division of Vocational Rehabilitation to provide physical restoration and workshop experience for disabled persons.

The Division of Vocational Rehabilitation

The Vocational Rehabilitation division has four planning areas in the state. Definite plans have been put in operation to accommodate the backlog of persons awaiting services and to provide a range of vocational rehabilitation services to physically and behaviorally handicapped persons. The continuum of service begins with diagnosis, from which a counselor determines the scope of need. Physical restoration, vocational training geared to individual need, vocational counseling, supplies and transportation, and job placement are integral parts of the division program.

The Special Education Section

The Special Education section, under the Division of Vocational Rehabilitation, determines the special education services provided through the state's school districts, which are involved in the planning process. The services involve special classes for handicapped children who need special instruction and services in addition to, or separate from, regular classroom instruction.

The Division of Administration

The division of Administration is responsible for the overall coordination of services within the department, as well as certi-

fixation of teachers. Title I, ESEA, planning is through four regional offices at St. Paul, Bemidji, Brainerd, and Slayton. Funding is provided for programs for educationally disadvantaged children who achieve at one or more years below grade level in school. Some of this funding goes to classes for the mentally retarded, but it is expected that most of the mentally retarded children will be served in regular school programs in the future. (See page 101 for further discussion of Title I.) Among the special schools receiving Title I funds are the Braille and Sight-Saving School, the Minnesota School for the Deaf, and Gillette Children's Hospital.

The Division of Planning and Development

The Division of Planning and Development was established in 1968; it develops statewide education programs, and coordinates federal funds. Title III, ESEA, administered by the Innovation section, provides funding for innovative and exemplary programs within individual school districts throughout the state. Fifteen percent of the funding is allocated to. Programs for children with all types of handicaps. Title IV, ESEA, administered by the Evaluation Audit Section, develops workshops to teach schools methods of program evaluation and audit in the school districts. Title IV, ESEA, administered by the Planning section, is invested in all sections of the department of education; funding is monitored in cooperation with seven other states. The Equal Education Opportunity section develops the broad philosophies and long-range goals for the Department of Education.

1.5- The Department of Manpower Services

The Manpower Services Department (Figure 5) provides employment counseling and testing, and assists persons in job placement.

DEPARTMENT OF MANPOWER SERVICES

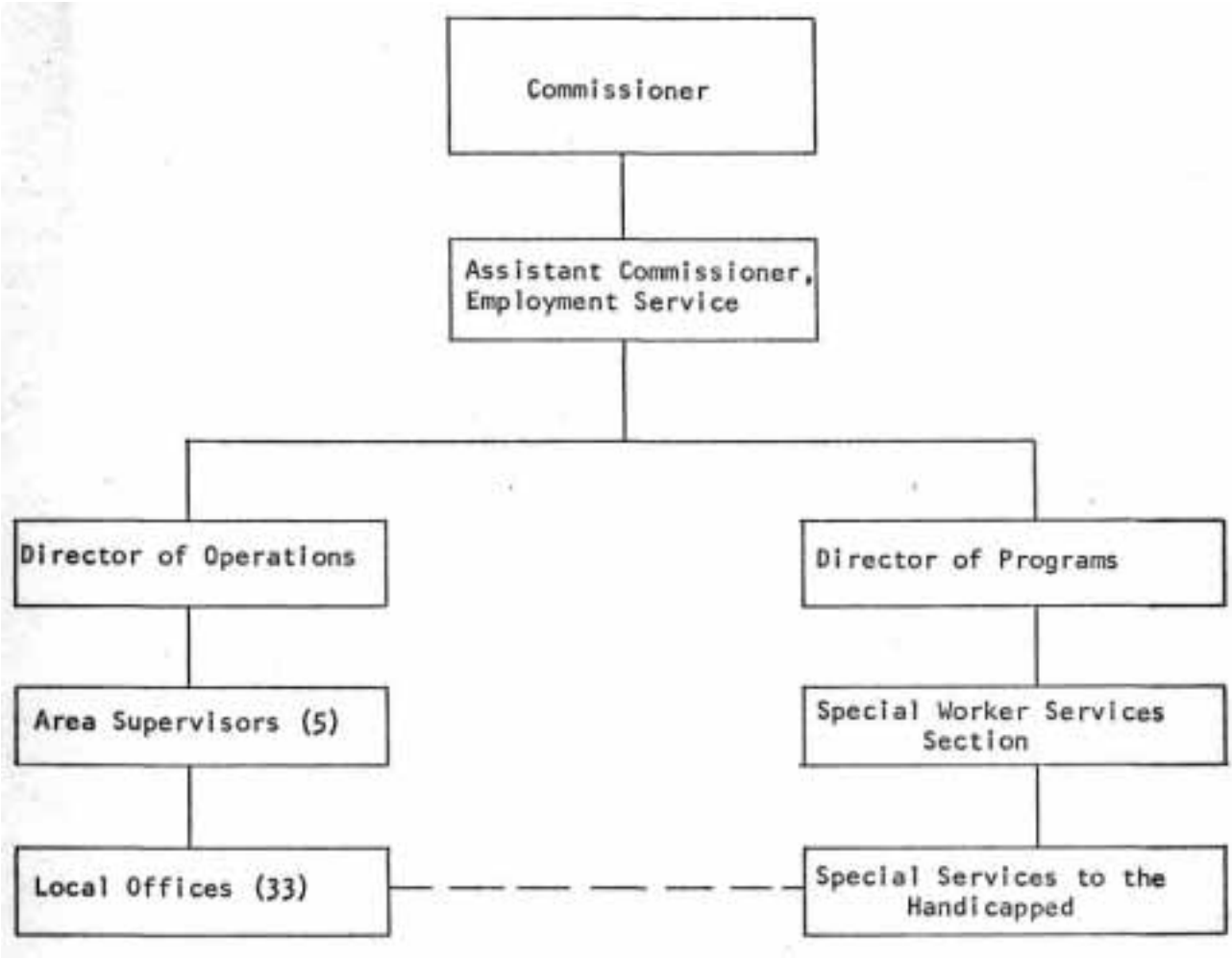


Figure 5

Special programs assist applicants with special needs, such as handicapped and otherwise disadvantaged persons. The Special Services for the Handicapped program is integrated into the local office operations and is supervised at the state level under the direction of the Chief of Special Worker Services.

The Minnesota Advisory Board on Handicapped, Gifted, and Exceptional Children

Although established and funded under the Special Education Law, the Advisory Board on Handicapped, Gifted, and Exceptional Children is advisory to the State Board of Education, the Commissioner of Public Welfare, the State Board of Health, and the Department of Corrections. The twelve members are appointed by the Governor and the reports developed are issued as Governor's Reports.

The board aids in formulating policies and encouraging programs for exceptional children.

1.6 The Governor's Commission on Employment of Handicapped Persons

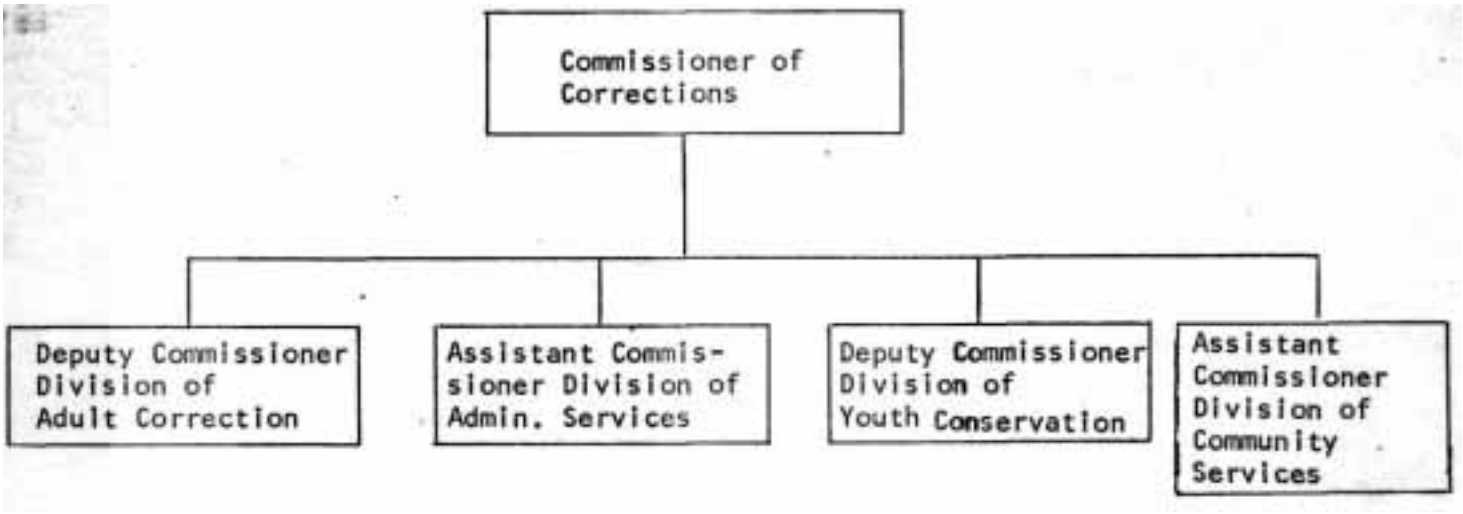
The Governor's Commission on Employment of Handicapped Persons was created by legislation in 1965. The nineteen member board is appointed by the Governor and represents business and industry, labor, the handicapped, and the general public.

The broad objective of the Council is "to secure for physically, mentally, emotionally, and otherwise handicapped citizens of Minnesota equal opportunity in preparing for and obtaining employment suited to their abilities and capacities in public service, private enterprise, and other fields of employment."

1.7 The Department of Corrections

The Department of Corrections (Figure 6) provides programs of correctional service. The department is responsible for protection of the public and for assisting offenders to attain a life style compatible with society. The programs include education, counseling, vocational training, and work. Among the persons served by the department are some with developmental disabilities. The department is in the process of reorganization to the arrangement shown below.

Figure 6: DEPARTMENT OF CORRECTIONS



Chapter 2. REGIONAL STRUCTURES FOR SERVICES AND PLANNING

The State of Minnesota is divided into various regions for the provision of services and for planning purposes. There is wide variance in the size of these areas and the location of their boundaries, despite efforts to define planning areas uniformly.

This chapter contains a number of maps that show the various service and planning boundaries now used. Also listed are potentials within the various private organizations for representation or participation in any regional planning for the developmentally disabled.

Map 1 shows the most recent boundaries for the 11 Development Regions of the state as designated by the Governor. Region 6 has been further divided into 6 East and 6 West as shown.

Map 2 shows both population centers and counties by one index of poverty. In Table 1 (source, the 1960 census), all counties are ranked, from the highest percent to the lowest percent of population with less than $3,000 annual income.

Map 3 shows the major road routes in the state to illustrate the relationship between transportation routes and regional development.

Map 4 shows the planning areas for the Area wide Comprehensive Health Planning Agencies.

Map 5 shows the location of the 25 Area Mental Health, Mental Retardation Programs and the counties served by each. Map 6

shows how these areas are combined into mental retardation regions and areas.

Map 7 gives the location of the county welfare department office in each of the 87 counties.

Map 8 shows the location of Department of Public Welfare institutions.

Map 9 shows the eight districts and offices of the Department of Health.

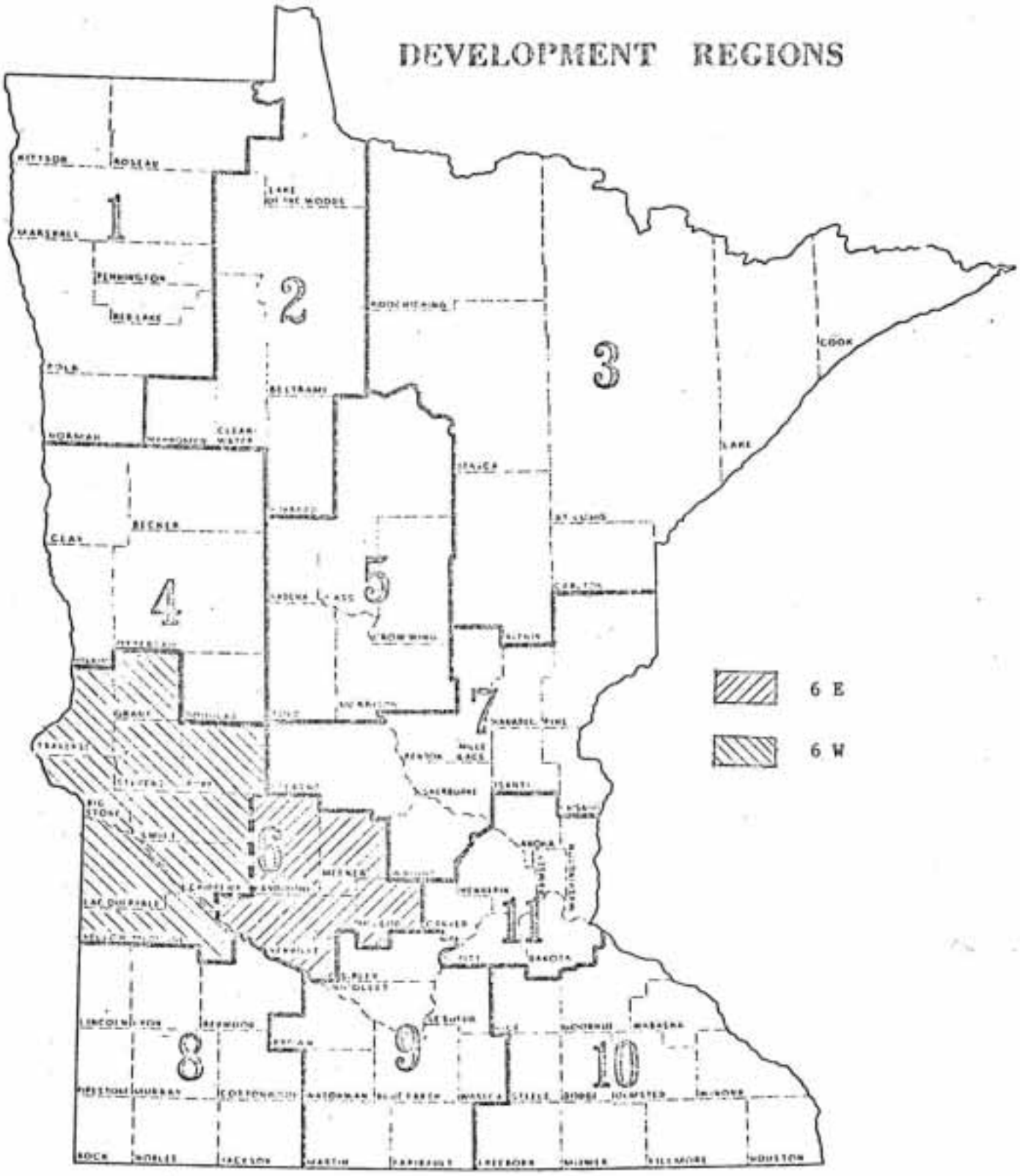
Map 10 shows the seven planning areas used by the Department of Education for planning purposes until their most recent changes and their relationship to the 11 economic regions. The regional efforts of the Special Education Sections still use these boundaries.

Map 11 shows the boundaries used by the Division of Vocational Rehabilitation for its four planning and supervising regions.

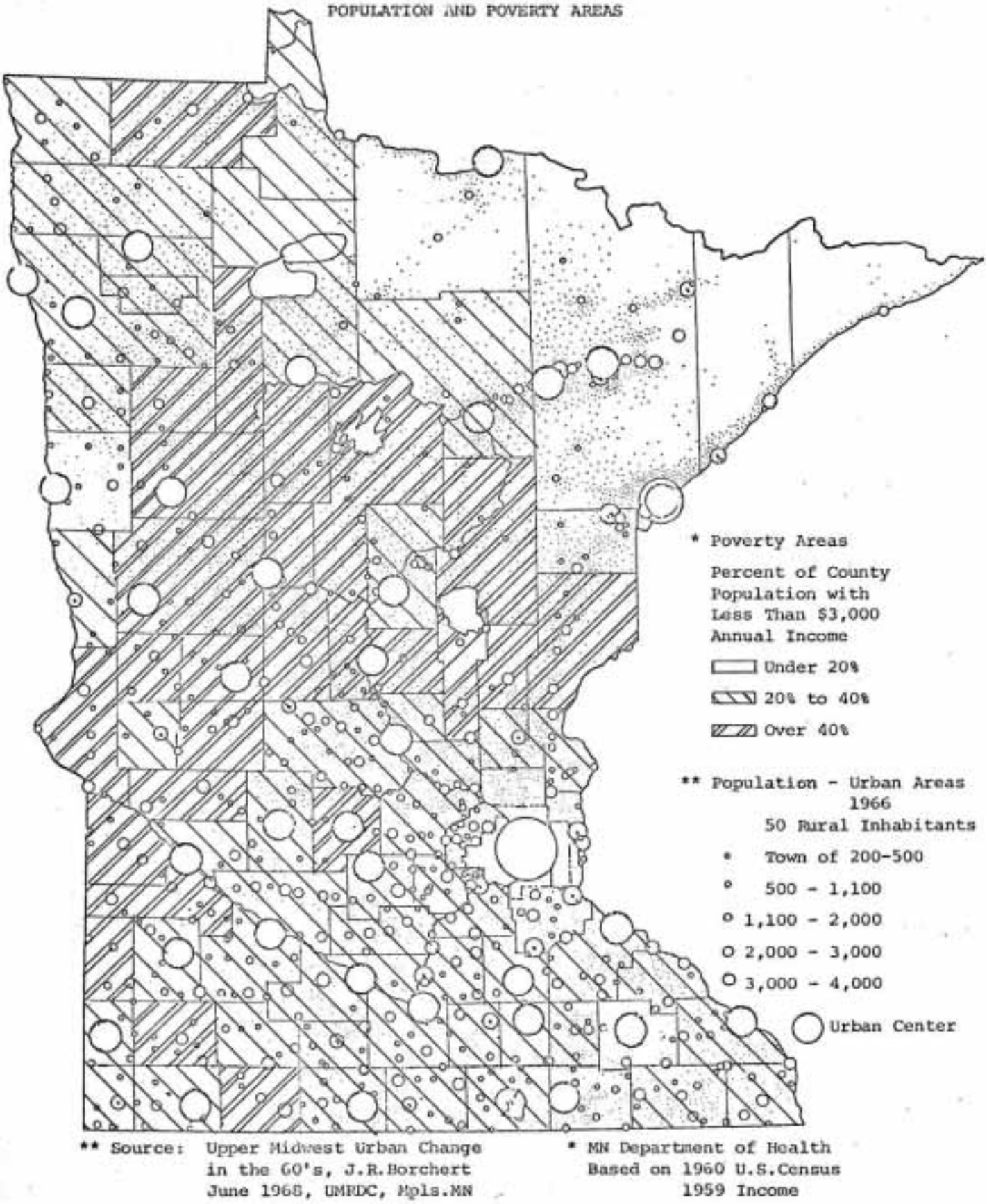
Map 12 shows the six districts and local full-time offices of the Department of Manpower Services. The two districts numbered "5" are supervised by the same person.

Map 13 shows the eight regions proposed by the Department of Corrections for regional services. The page following describes the relationship to the 11 Development Regions.

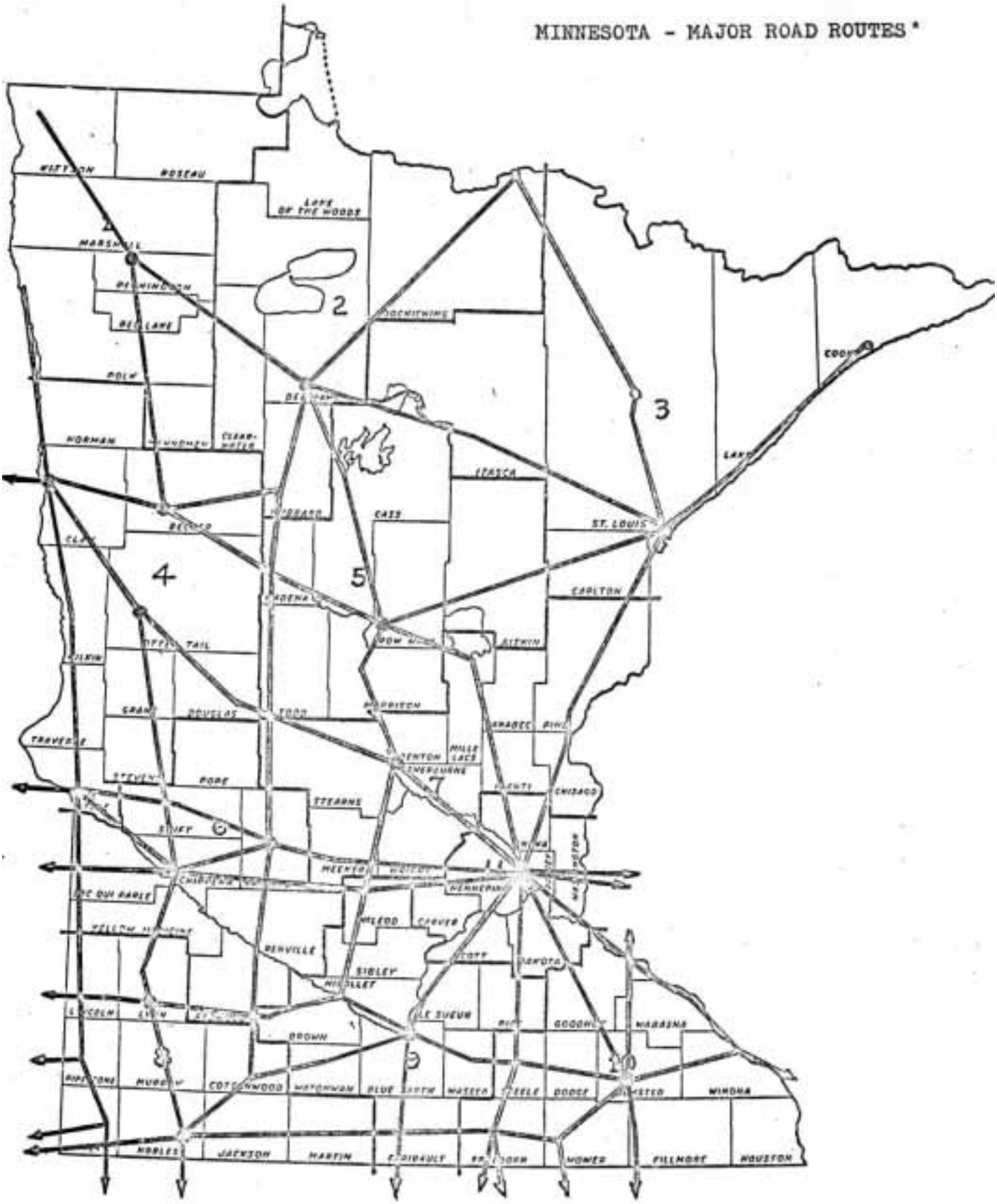
On page 37 are described other agencies with potential input for regional planning.



Map 1


POPULATION AND POVERTY AREAS
* Poverty Areas
Percent of County Population with Less Than $3,000 Annual Income
Under 20%
20% to 40%
Over 40%
** Population - Urban Areas 1966
50 Rural Inhabitants
Town of 200-500
500 - 1,100
1,100 - 2,000
2,000 - 3,000
3,000 - 4,000
Urban Center
** Source: Upper Midwest Urban Change in the 60's, J.R.Borchert June 1968, UMRDC, Mpls.MN
* MN Department of Health Based on 1960 U.S.Census 1959 Income

Map 2



*Regional Development Systems in Minnesota, John S. Hoyt Jr.

Map 3

AREA WIDE COMPREHENSIVE HEALTH PLANNING AGENCIES

Map 4

AREA WIDE COMPREHENSIVE HEALTH PLANNING AGENCIES

ARCH. Arrowhead Region Planning Council for Health Facilities and Services 900 Alworth Building, Duluth, Minnesota 55802

AGASSIZ Health Planning Council, Highway 220 North, East Grand Forks, Minnesota 56721. Agassiz includes Pembina, Walsh, Nelson, and Grand Forks Counties in North Dakota.

CENTRAL Minnesota Council for Health Facilities and Services 605 Medical Arts Building, St. Cloud, Minnesota 56301

METROPOLITAN Health Board, Metropolitan Council, Suite 101, Capitol Square Building, 550 Cedar Street, St. Paul, Minnesota 55101

MIN-DAK Area wide Comprehensive Health Planning Council, 200-5th Street, Moorhead, Minnesota 56560. Min-Dak includes Steele, Traill, Cass, Ransom, Sargent, and Richland Counties in North Dakota.

S.E. Southeastern Minnesota Health Planning Council is presently staffed by State Comprehensive Health Planning Program personnel.

S.C. South Central Minnesota has not yet incorporated.

S.W. Southwestern Minnesota Health Planning Council is presently staffed by State Comprehensive Health Planning Program personnel.

*Pipestone and Rock Counties in Minnesota have joined with Lyon County, Iowa, and McCook, Minnehaha, Turner, and Lincoln Counties in South Dakota to form the MID Health Planning Council.

AREA WIDE COMPREHENSIVE HEALTH PLANNING

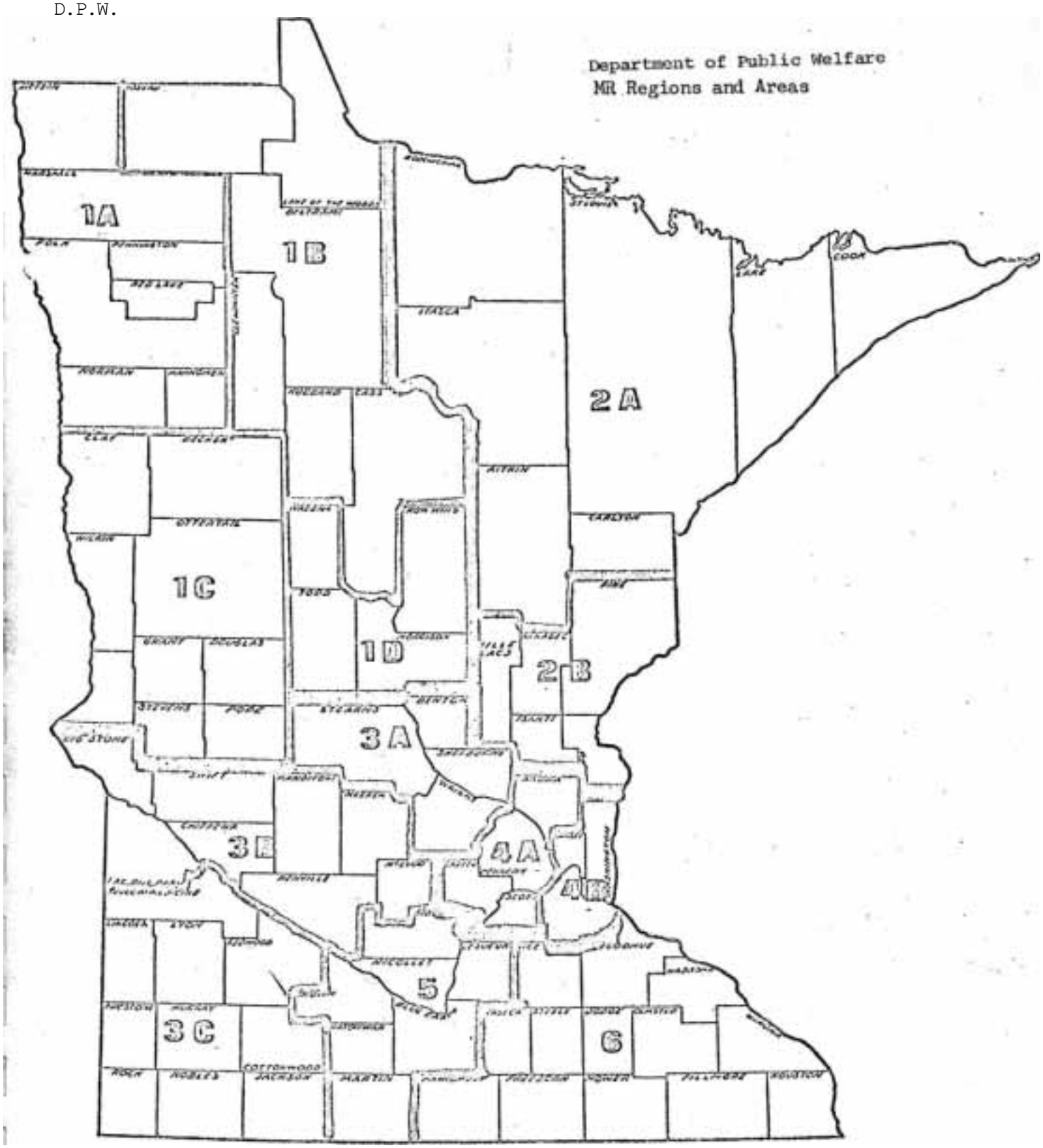
Area wide health planning organizations are being formed throughout the state. These organizations, called area wide comprehensive health planning councils, are composed of groups of counties which share common problems and resources and which have sufficient population to support a full range of health services, facilities, and manpower. By law each area wide health planning council, like the state counterpart, has a governing board having a majority of consumers of health services. Such area wide health planning councils stimulate local groups, agencies, institutions, and individuals responsible for the planning or providing of health services to. coordinate their activities and resources. This cooperation at the local level reduces duplication of efforts, fragmentation of services, and the misuse of scarce professional manpower, which can result in the spiralling of health care costs.

Area wide health planning councils also are responsible for identifying and planning for unmet community needs. It is such identification and planning which will assure all people within the area access to efficient, economical, high quality health services and the maintenance of a healthful physical environment.

In sum, Minnesota Comprehensive Health Planning is built upon the three key elements: Comprehensive Planning, Partnership, and Consumer Participation. Each element is indispensable to the planning for, and the provision of, available, acceptable, accessible health services for all Minnesota citizens.

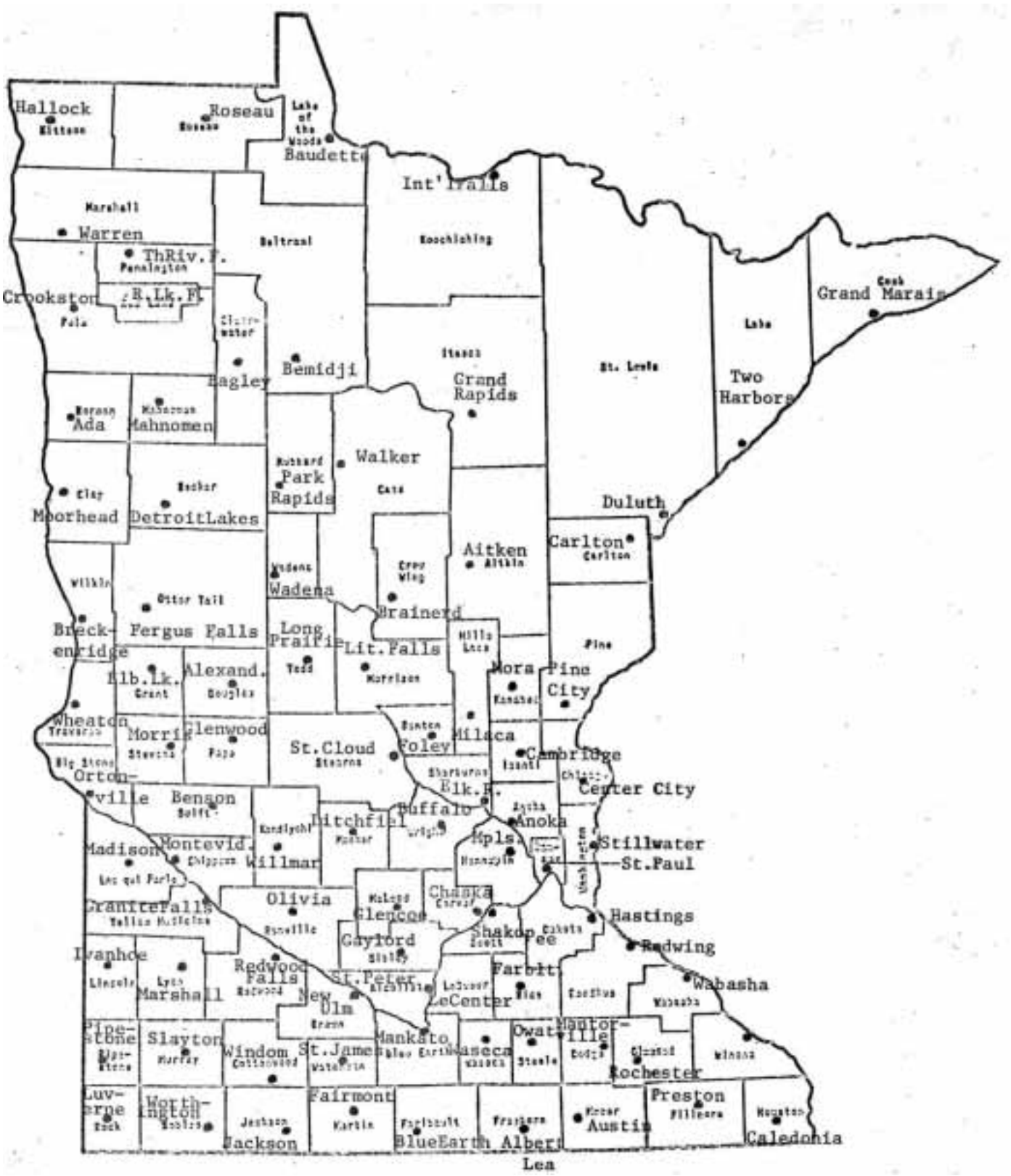
MINNESOTA'S AREA MENTAL HEALTH-MENTAL RETARDATION PROGRAMS

From M.R. Facil. Constr.Plan Dec. 1969
D.P.W.



Map 6

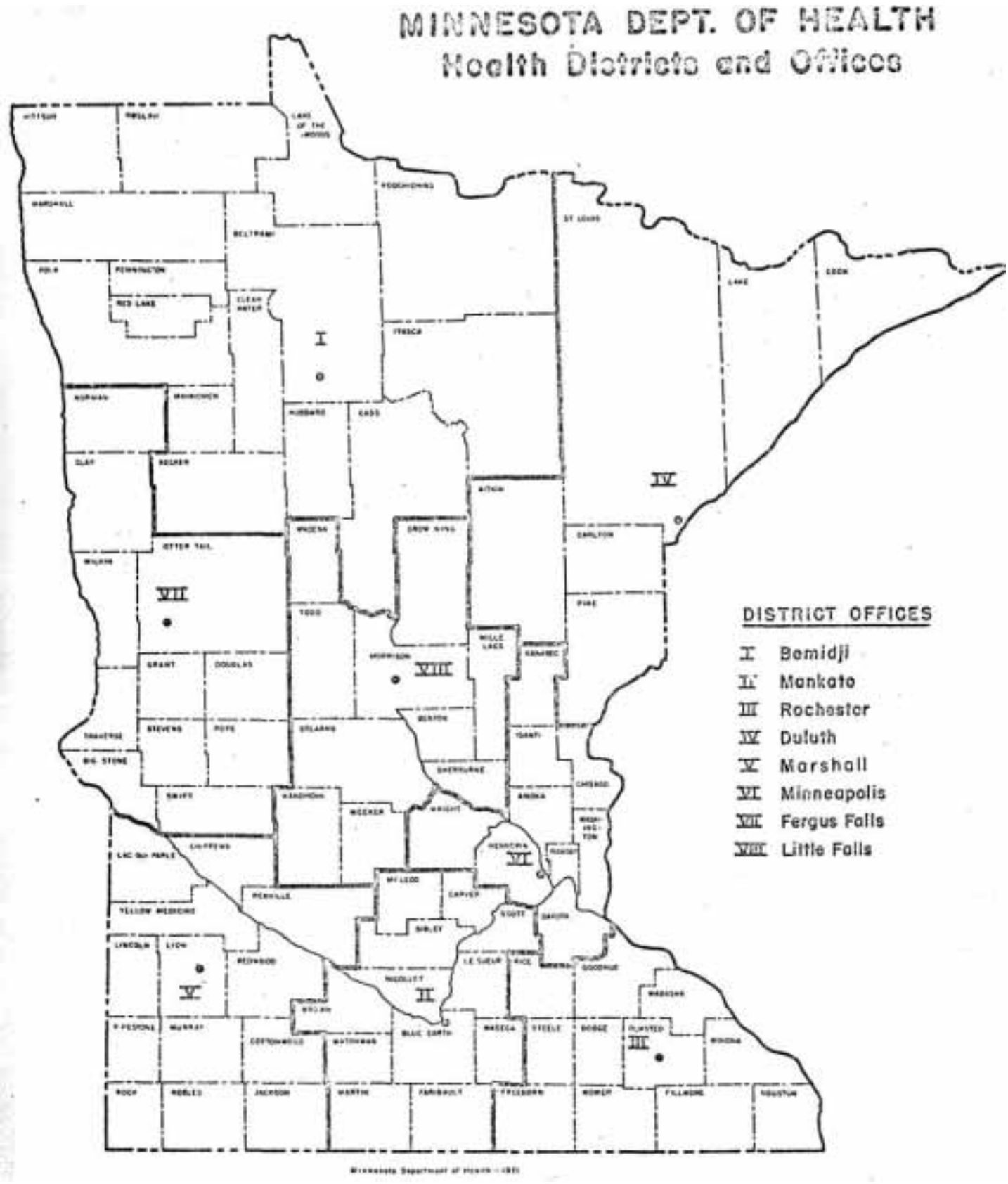
County Welfare Offices



Map. 7

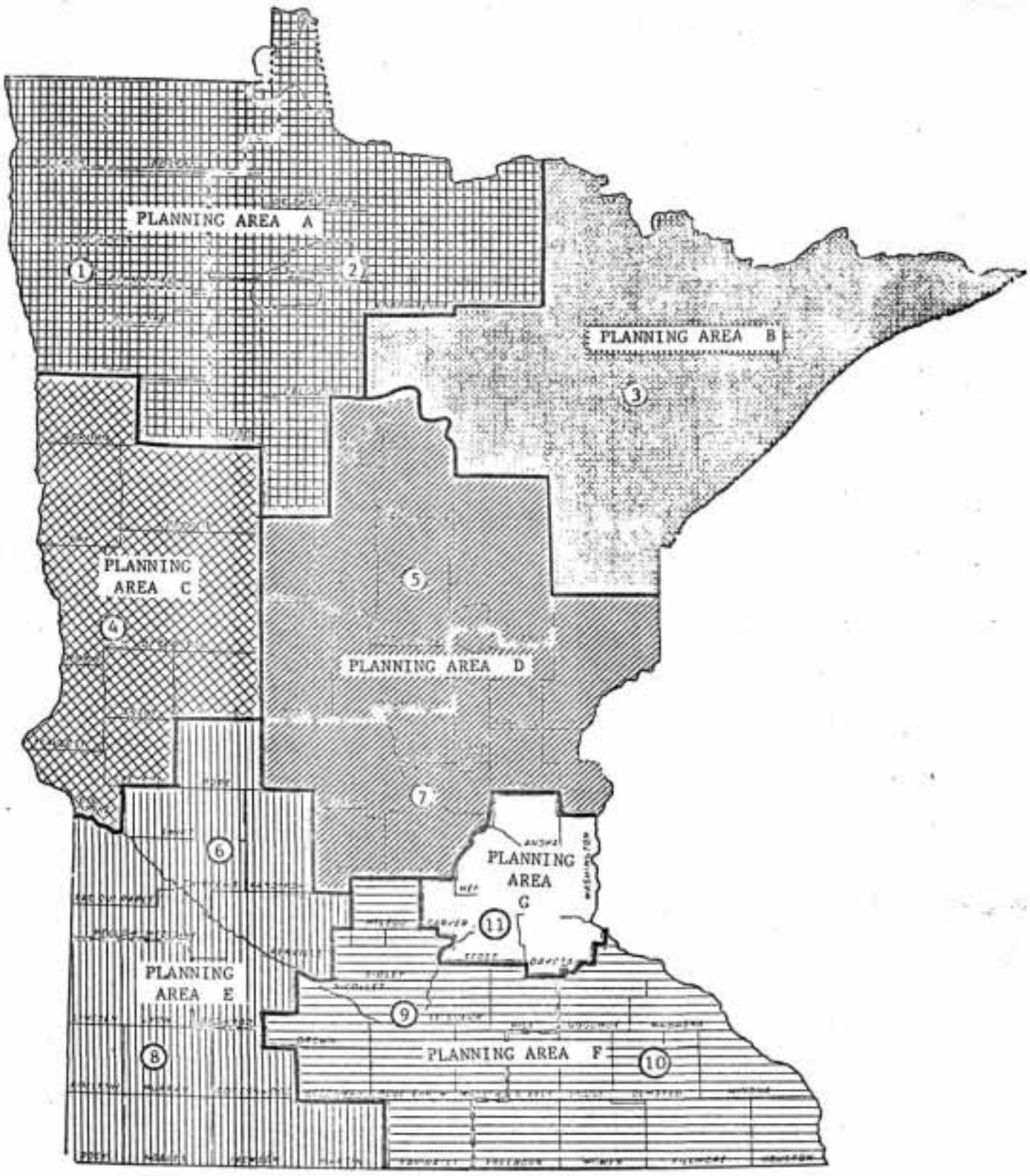
Department of Public Welfare Institutions

Map 8


MINNESOTA DEPT. OF HEALTH
Health Districts and Offices
DISTRICT OFFICES
I Bemidji
II Mankato
III Rochester
IV Duluth
V Marshall
VI Minneapolis
VII Fergus Falls
VIII Little Falls

Map 9

DEPARTMENT OF EDUCATION PLANNING AREAS



Map 10

DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION PLANNING AREAS

Map 11

DEPARTMENT 0F MANPOWER SERVICES
DISTRICT BOUNDARIES AND FULL-TIME OFFICES

Map 12

DEPARTMENT OF CORRECTIONS

Map 13

REGIONAL DELINEATION

RECOMMENDATION: An analysis of the jailing and detention needs in Minnesota suggests the development of eight regions able to economically operate within a state-wide regionalization program.

REGIONAL RECOMMENDATIONS

A comprehensive plan for regional jails and regional detention necessarily requires an analysis of the counties that are recommended to form a particular region. The starting point for such an analysis was the Minnesota Development Regions as outlined in Executive Order No. 60 pursuant to authority granted to the governor by the Minnesota State Legislature to define regional boundaries.

Thus, the Minnesota Development Regions were analyzed to determine whether these regions had a sufficient inmate population and a sufficient juvenile detention need to meet the requirements for 12,000 days of care for a regional jail, 6,000 days of care for regional detention, or 11,000 days of care for a facility that combined a regional jail and detention center. If a Minnesota Development Region could not meet one of these requirements, it would be too costly for a group of county governmental units to operate and therefore, it would have to be combined with a larger number of counties.

The map on the following page lists the recommended eight regions and the counties involved in each region.

The Northwest Region includes Development Regions 1 and 2, since neither Development Region can achieve the recommended days of care alone. Cass County was also included since Development Region 5 cannot operate by itself. It has neither the inmate or juvenile population nor money to establish and operate under a regionalization program. Therefore, due to the proximity of the county seat of Cass County to this region, Cass County was included in the Northwest Region.

The Northeast Region coincides with Development Region S.

The West-Central Region is Minnesota Development Region 4. Wadena County, however, was also included from Development Region 5 since it could not operate a facility by itself.

The East-Central Region is Minnesota Development Region 7. Crow Wing, Todd and Morrison Counties were included because Development Region 5 could not support a regional plan by itself. Cass and Wadena County were not included from Development Region 5 because of the distance.

The Southwest Region is Minnesota Development Region 6 and 8. This was necessary since neither Development Region has a sufficient jail population or juvenile detention need to achieve the needed days of care.

The South-Central Region is Minnesota Development Region 9. It also includes Freeborn County from Development Region 10 in order that the South-Central Region can achieve the required days of care.

The Southeastern Region is Minnesota Development Region 10 except for Freeborn County which was shifted into the South-Central Region.

The Metropolitan Region coincides with Development Region 11.

Map 13 (cont'd)

2.1 Other Potential Input For Regional Planning

Governor's Commission for Employment of Handicapped Persons The Commission has Area Councils operating in Minneapolis, St. Paul, St. Cloud, Duluth, Steele County, Clay County, Rochester, and Mankato. The Commission's goal is ultimately to have 30 or more such local area councils throughout the state. The Governor's Commission and local area councils have a wide range of representatives of business and industry, public agencies, private agencies, and the general public.

Minnesota Advisory Board on Handicapped, Gifted, and Exceptional Children
The Board has representatives from each of the state's eight congressional districts and four members at large, appointed by the Governor.

Minnesota Association for Retarded Children, Inc. MARC has 81 local units covering all but two counties. They have nine regional field representatives providing assistance to the local units in 12 regions. These regions, with a couple of exceptions, coincide with the mental-health, mental-retardation area boundaries.

United Cerebral Palsy of Minnesota
United Cerebral Palsy currently has six local units in the state: Minneapolis, St. Paul, Duluth, Mower County (Austin), Iron Range, and Central Minnesota (three counties around St. Cloud). The organization is working to establish more such local units.

Minnesota Epilepsy League
The Epilepsy League has local chapters in Minneapolis, St. Paul, Duluth, Tri-County (around St. Cloud) and Mankato-St. Peter.

Efforts are underway to establish more local chapters throughout the state.

Mental Health Association of Minnesota

The Mental Health Association has 19 county chapters throughout the state and plans to change to a regional system of affiliate chapters in 1972. Five additional chapters are being formed. The Association has field representatives working with all local chapters.

Table 1. RANKING OF COUNTIES BY PERCENT OF PEOPLE WITH INCOMES LESS THAN $3,000 *

PERCENT BELOW $3,000	COUNTY	RANK
50.3	TODD	1
49.7	CASS	2
49.0	AITKIN	3
48.7	LAC QUI PARLE	4
47.9	LINCOLN	5
47.9	MAHNOMEN	5
47.2	BIGSTONE	7
46.1	WADENA	8
46.1	CLEARWATER	8
44.5	HUBBARD	10
43.2	YELLOW MEDICINE	11
43.0	JACKSON	12
42.3	TRAVERSE	13
42.0	GRANT	14
41.9	PINE	15
41.7	MEEKER	16
41.6	DOUGLAS	17
41.2	OTTEPTAIL	18
41.0	ROSEAU	19
40.8	KANABEC	20
40.5	POPE	21
40.4	MURRAY	22
40.3	MORRISON	23
40.2	MILLE LACS	24
40.1	SWIFT	25
40.0	BECKER	26
39.9	REDWOOD	27
39.6	RENVILLE	28
38.5	PIPESTONE	29
38.1	SIBLEY	30
37.8	STEVENS	31
37.5	FILLMORE	32
37.4	NORMAN	33
37.1	CHIPPEWA	34
36.7	COTTONWOOD	35
36.3	LAKEWOOD	36
35.9	DODGE	37
35.4	MARSHALL	38
35.2	BELTRAMI	39
35.2	WATONWAN	39
34.9	KITTSON	41
34.8	LESUEUR	42
34.7	NOBLES	43
34.5	ISANTI	44
33.6	LYON	45
33.6	REDLAKE	45
32.9	FARIBAULT	47

Table 1

Table 1 (cont'd)

32.7	KANDIYOHI	48
32.3	ROCK	49
32.1	HOUSTON	50
32.1	WILKIN	51
31.8	WRIGHT	52
31.0	BROWN	53
30.9	MCLEOD	54
30.7	MARTIN	55
30.2	CHISAGO	56
30.0	WABASHA	57
29.8	PENNINGTON	58
29.8	BENTON	59
29.0	WASECA	60
27.6	POLK	61
27.5	CROW WING	62
27.3	STEARNS	63
26.5	ITASCA	64
26.4	SCOTT	65
25.7	BLUE EARTH	66
25.2	GOODHUE	67
24.8	RICE	68
24.7	SHERBURNE	69
24.5	CARVER	70
24.3	FREEBORN	71
23.9	WINONA	72
22.5	STEELE	73
22.0	NICOLLET	74
19.4	MOWER	75
17.6	ST LOUIS	76
17.3	CARLTON	77
17.0	CLAY	78
16.5	OLMSTED	79
16.3	COOK	80
15.4	KOOCHICHING	81
11.9	LAKE	82
11.6	WASHINGTON	83
10.3	HENNEPIN	84
10.2	RAMSEY	85
9.8	DAKOTA	86
6.8	ANOKA	87

*Based on 1960 U.S. Census, 1959 income.
Minnesota Department of Health.

Chapter 3. PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

The two tables on the following pages provide an overview of the numbers of developmentally disabled persons in Minnesota who are served by both public and private programs and the amounts of governmental and other funds that support these programs.

Program descriptions are provided for the following agencies and organizations as they relate to the developmentally disabled:

1. Department of Public Welfare (13 separate programs);
2. Department of Health (6 programs);
3. Department of Education (4 programs);
4. Department of Manpower Services;
5. Department of Corrections;
6. Governor's Commission on Employment of Handicapped Persons;
7. Minnesota Advisory Board for Handicapped, Gifted, and Exceptional Children;
8. Minnesota Association for Retarded Children;
9. United Cerebral Palsy of Minnesota;
10. Minnesota Epilepsy League;
11. Minnesota Rehabilitation Association;
12. Minnesota Association of Rehabilitation Facilities;
13. Minnesota Administrators of Special Education;
14. Minnesota Association of Mental Health and Mental Retardation Programs;
15. Mental Health Association of Minnesota.

For each program described in this section, some or all of the following information is included: numbers and categories of developmentally disabled persons served, types of service, information system, staff, unmet need, and additional activities that would be planned if monies were allocated.

See Chapter 6 for a discussion of the information-collection and planning methods used by the agencies. In Chapter 7 the unmet needs identified by the agencies are discussed.

Table 2

~~ESTIMATES OF DEVELOPMENTALLY DISABLED PEOPLE SERVED IN MINNESOTA~~

Clientele of DD programs by Dept., based on 1971 information

Program	Number Served	Comments
WELFARE		
Crippled Children Services	210 Epileptic 970 Cerebral palsy	Served last fiscal year
Minnesota State Services for the Blind	191	Developmentally disabled in last fiscal year
Braille and Sight Saving School	26	Developmentally disabled served last fiscal year
Services for Deaf	120	Developmentally disabled served last fiscal year
Minnesota School for Deaf	13 Cerebral palsy 3 Epileptic	Served last year
Gillette Cerebral Palsy Clinic	900	Served last year. No figures available for Epilepsy Clinic
Public Operations Office	200	Developmentally disabled served last year
Regional Centers for Retarded Institutions	4,200	Average population last year
Cost-of-Care	764 MR	Served Fy 1971
Day Activity Centers (102)	2,400	Developmentally disabled served last year
Family and Guardianship	9,005	Mentally retarded under guardianship last year
HEALTH		
Child Study Center -- Owatonna	70	New cases last year, retarded
Child Development Center -- Fergus Falls	171	New cases seen last year (Number of retarded not known)

ESTIMATES OF DEVELOPMENTALLY DISABLED PEOPLE SERVED IN MINNESOTA

Program	Number Served	Comments
EDUCATION		
Division of Vocational Rehabilitation	7,200	Developmentally disabled served last year
Special Education	27,000	Mentally retarded in special education classes this year
Title 1	1,400	Mentally retarded served this year in institutions
Vocational-Technical	4,640	Mentally retarded served 1970-71 school year
Department of Corrections	43	Total mentally retarded youth and adults in institutions June 30, 1970
	121	Total number of persons with borderline intelligence in institutions, June 30, 1970
Department of Manpower Service		No information
Minnesota Association for Retarded Children		
Foster Grandparent Program	276 MR children	To be served this year
Camp Friendship	1,100	Mentally retarded participants each year
Special Olympics	800	Total participants in state each year
United Cerebral Palsy Statewide Diagnostic and Evaluation Clinics	108	New cases evaluated each year
Private Rehabilitation Facilities	9,000	All handicapped served last year in 40 facilities (percentage developmentally disabled unknown.)

Table 2 (cont'd)

Table 2 (cont'd)

ESTIMATES OF DEVELOPMENTALLY DISABLED PERSONS SERVED IN MINNESOTA

Program	Number Served	Comments
EDUCATION (continued)		
Private Residential Facilities	656 retarded children 1,012 retarded adults	
Private foster homes	1,284 retarded children	1969-1970
Special Schools (Fraser, Sheltering Arms and Christ Child School)	315 retarded	Ages 2-1/2 - 23

Table 3: BUDGET SUMMARIES

PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

Program	Federal	State	Other	Comments
WELFARE				
Crippled Children Services	$935,000	$100,000		
Minnesota State Services for the Blind	$1,604,000	$355,000	$53,000	Total Program.
Minnesota Braille and Sightsaving School	$82,000	$718,000	$2,350	Federal money is ESEA Title I, IV; Total program.
Services for the Deaf		$30,000		Total program.
Minnesota School for the Deaf	$86,000	$1,303,000		Federal money is ESEA Title I; Total program
Gillette Childrens Hospital	$16,960	$2,300,000		Total program.
Public Operations Office		$15,000		Estimate
Faribault, Cambridge, and Brainerd Institutions for the Retarded	$7,511,000	$19,500,000	$67,000	
Cost of Care		$1,122,000	$1,100,000 county	
Day Activity Center		$1,400,000	$2,335,000 local	1971-1972
Family and Guardianship				No information

Table 3 (cont'd)

Prog	Fed	Sta	Other	Comments
HEALTH				
Human Genetics	$21,900	$14,100		July, 1970 - March 31, 1971
PKUL	$6,700	$11,000		July, 1970 - March 31, 1971
Cytogenetic Laboratory	$15,870	$8,655		July, 1970 - March 31, 1971
Child Study Center Owatonna	$60,000			Health Department portion of total program.
Child Development Center Fergus Falls	$68,000			Health Department portion of total program.
EDUCATION				
DVR			$11,655,000 Total all sources.	Fy 1971; total program
Special Education, Titles I & III; EHA Part B	$2,400,000	$19,000,000	Local unknown.	
Vocational-Technical	$753,000		$502,000	1971-72 program for all handicapped.
Manpower Services				Unknown
Corrections				Unknown
Minnesota Advisory Board				Reimbursed expenses of board members only.
Governor's Commission on Employment of the Handicapped		$30,000		Approximate
Minnesota Association for Retarded Children			$330,000	Staff and administration expenses.
Foster Grandparent Program	$300,000	$12,500		
Camp Friendship			$90,000	
Minnesota Epilepsy League			$10,000	
Minnesota Rehabilitation Assoc.			$2,500	

3.1 Department of Public Welfare

Crippled Children Services, Rehabilitative Services Division

The program has been operating since 1935. Its objectives are to locate children in Minnesota up to 21 years of age who are handicapped and, if their parents cannot provide the necessary care and are eligible according to the guidelines established by the Commissioner of Welfare, to provide the children with specialized medical and dental evaluation, treatment, follow-up, and preventive services to the limit of funds. Service is purchased from medical centers and specialists. Funds are not available for routine medical care, psychiatric care, boarding care, custodial care, or transportation.

Need for service is mostly determined through screening and diagnosis at field clinics by a health team. All who are accepted are given whatever medical and dental treatment they need that can be provided by allocated state and federal funds.

Of the 7,576 clients served last year, including those receiving services at Gillette Children's Hospital, 1,026 were mentally retarded, 970 had cerebral palsy, and 210 were diagnosed as epileptic. More than 40% of the total clients had more than one handicap. (Handicaps are recorded separately.)

The federal share for fiscal 1971 is $935,000; the state's share is $100,000. No budget changes are being planned.

Most frequent referrals are from physicians, nurses, social workers, and parents. There is no indication of the proportion of referrals to other agencies from Crippled Children Services. Twenty-five professional staff provide direct client service and also consultation service.

Follow-up is made and further service is given if it is possible to do so within the limits of staff and transportation facilities.

Minnesota State Services for the Blind, Rehabilitative Services Division, Department of Public Welfare

The program began in 1923. The objective is to provide social, psychological, financial, educational, and vocational rehabilitation to the visually handicapped of all ages. It is estimated that 30% of the clients could be included among the developmentally disabled.

Most persons are referred by county welfare personnel. The services are available to all eligible persons. Twenty-three percent of the applicants or 34% of last year's referrals did not meet the eligibility criteria for being "blind disabled." Projections show that another 30,000 persons not currently eligible could benefit from the State Services for the Blind.

Purchased services are medical diagnosis and treatment, vocational training, compensatory skill training, and physical restoration. Provided services are counseling, training for daily living and leisure time activity, and such special education aides as "talking-book" machines. Consultation and referral services are made to appropriate community agency resources. The client's record shows only one other secondary handicap in addition to visual disability.

There are five full- and 16 part-time staff members in the children's program; 11 full- and 16 part-time staff members -in the vocational rehabilitation program; and 16 part-time staff members in the self-care program. They are selected through Civil Service procedures. The breakdown of the staffs, according to titles and numbers, is as follows: rehabilitation counselors (30); orientation and mobility specialists (two); placement specialists (two); deaf-blind specialist (one); and

psychologist (one). In addition, there are 36 full- and six part-time staff members serving other functions.

Program evaluation is by program budget with state and federal program cost/benefit audits. Cost/benefit is calculated by dividing the numbers served and rehabilitated by the cost; and by cost per treatment and diagnosis-category per individual. Cases are followed-up by periodic studies, a computer recall system, and a systematic review of closed cases. The program reports 440 successes and 108 program drop outs. Among the successes are 359 in the vocational rehabilitation program, 38 in the children's program, and 43 in the self-care program.

The program's funds are in the amounts of $355,000 in state funds, $1,604,000 in federal funds, and $53,097 in a Hamm Foundation grant for the communications center. Additional funds would be used for increasing the staff, developing cooperative agreements for service to children and institutionalized persons, expanding present services, and providing communication center services.

Services for the Deaf, Rehabilitative Services Division, Department of Public Welfare

The program, which began in 1957, provides counseling and casework services to persons whose hearing is impaired. Interpretive services are provided to courts, schools, and other social agencies. Educational placements in local schools and the Minnesota School for the Deaf are arranged in cooperation with the Department of Education and the School for the Deaf.

Services are available, without regard to eligibility or need, to all persons whose hearing is impaired and who request help. Liaison is maintained with the Division of Vocational Rehabilitation. Referrals most often come from the individual, county welfare caseworkers, police, and schools.

Persons with developmental hearing disabilities are estimated to be about 30% to 40% of the 350 to 400 clients served last year. Services are initiated upon request and each referral receives at least one contact or interview. To date, there has been no attempt to gather statistics on selected groups of clients. It was estimated that an additional 300-350 could be served. Multiple disabilities are recorded individually on the registry card and in the narrative of the case record.

Expressed in terms of full-time equivalents, the central office staff consists of 1 1/4 counselor providing direct service. Staff are selected through Civil Service procedures.

The program budget is approximately $30,000 in state money.

Evaluation and follow-up are not attempted.

Additional funds, if available, would be used for two additional counselors and one clerk-typist, and for more service to deaf clients living outside of the seven-county metropolitan area. Legislative approval is required for additional staff.

Minnesota School for the Deaf, Rehabilitative Services Division, Department of Public Welfare

This program was begun in 1863 to provide education for hearing-handicapped children of normal intelligence. Objectives are to develop to the fullest language, speech, and residual learning; provide prevocational and vocational counseling and guidance; and, if applicable, prepare students for admission to the national college for the deaf. The Faribault school admits children who have sufficient hearing loss to have difficulty in public schools. Current enrollment includes 13 children with cerebral palsy, three who have epilepsy, and 42 to 50 who function as mentally retarded individuals due primarily to multiple disabilities.

Specialized instruction is available to any child in need of additional service. All of the developmentally disabled are receiving specialized instruction.

The academic course of study is much the same as that in the public schools of the state. The average student requires 14 years to complete the requirements for graduation. It is impossible for the deaf child to make as rapid progress in his studies as the hearing child, even though the handicap is largely overcome by the highly skilled, intensive, and individualized special instruction given.

The first few years are devoted almost entirely to the teaching of speech, speech-reading, and language. As the understanding and use of language become well established, more and more attention is devoted to the usual studies.

A few pupils who have lost their hearing while in the public schools are admitted and are given special training in speech reading, besides continuing their general schooling.

Capable students are prepared to take the examinations for entrance to Gallaudet College, Washington, D.C. This is the only college for the deaf in the world; it is supported by the federal government.

In addition to academic work, the School for the Deaf teaches each pupil some trade that will be helpful in gaining a livelihood after graduation. Junior and senior students are referred to the Division of Vocational Rehabilitation for vocational planning and may participate in an evaluation at the Minneapolis Rehabilitation Center. No information is available on whether or not services were denied or whether others could benefit.

This past year, 278 students from the ages of five to 20 were enrolled, 70% of whom have a profound hearing loss, 28% severe-to-profound, and 2% moderate-to-severe.

Handicaps are recorded with the medical history in the children's school records.

No further breakdown between provision for deaf-only students and the multiply handicapped is available.

The staff is selected through Civil Service procedures. The ratio of all students to special teachers averages six-to-one. This includes teachers of specialized subjects, such as industrial arts and home economics, the coaching staff, etc.

The program operates on $86,000 (Title I, ESEA) federal funds and $1,303,000 in state funds. If more funds were available, the school would add teachers and house-parents, so class size could be reduced and more individual attention be given to students in need of it.

Gillette Children's Hospital, Rehabilitative Services Division, Department of Public Welfare

Gillette Children's Hospital has been operating since 1897. Its objectives are to provide:

1. Comprehensive in- and outpatient diagnosis and treatment for children up to age 21 who have chronic disabling disorders;
2. Hospital and consultation services to children from other Department of Public Welfare facilities;
3. Training programs for residents in orthopedics and urology; and
4. Educational program for patients.

There are specialized clinics for patients with cerebral palsy and seizures as well as for patients with the diagnosis of scoliosis and myelomeningocele within the hospital. The Cerebral Palsy Clinics saw 900 children this past year. The seizure clinic saw about 100 patients. Total service for all disabilities included 1,000 in-patient and 6,000 out-patient visits per year.

The medical records of each client would need to be reviewed for further breakdown of services received by the developmentally disabled.

Patients are referred to Gillette by their personal physicians, public health nurses, or county welfare offices. Recent changes in eligibility are expected to increase the number referred by other agencies. The hospital offers a wide range of services and has a staff of 168 employees, in addition to its administrative and medical staffs.

No separate information is available for developmentally disabled patients on cost, staffing, evaluation, other agencies involved, follow-up after age 21, referrals, or indicating whether others could have been treated.

This program is funded by state monies of $2,300,000 per year, a Title I, ESEA, grant of $16,960, and bequest funds of approximately $50,000. If more funding were available, it would be used for experimenting with a minimum-care ward and for expanding the outpatient department.

Minnesota Braille & Sightsaving School, Rehabilitative Services Division, Department of Public Welfare

The program began in 1866. The primary objectives are to provide an academic course of study from kindergarten through grade twelve; to provide training in compensatory skills such as Braille and mobility training; to teach basic living skills and attitudes; and to provide vocational counseling and guidance. The program is open to any resident of the state between the ages of five and 20 for whom no appropriate public-school service exists.

All students receive services based upon individual evaluation and need. Multiply handicapped children receive specialized instruction. Children who are capable of doing so are integrated into many of the classes offered within the Faribault Public School Program. There were 76 students in this program last year, 16 in the deaf-blind unit and an additional 10 in the multiply handicapped unit. Disability information is included in individual student records.

Referrals are made by public schools and county welfare offices.

The pupil/special-teacher ratio averages four-to-one for the school (this includes teachers of special subjects such as industrial arts and home economics, the coaches, and so on). The staff is selected through Civil Service procedures. The school operates on a budget composed of $38,000 Title I, ESEA, and $44,431 Title IV Deaf-Blind federal grants; $718,000 in state monies; and $2,352 general-purpose bequest funds.

Additional funding, if it were available, would be used to develop an occupational therapy unit and to expand the deaf-blind program.

Mental Health - Mental Retardation - Inebriacy Boards, Community Programs Section, Medical Services Division, Department of Public Welfare

Creation of community mental-health boards was authorized by the 1957 Community Health Service Act. Any city, county, town or village, or any combination thereof of over 50,000 population, is allowed to establish a mental-health program under either public or private, non-profit board sponsorship. Since then, all counties of the state have organized to form 25 area Mental Health, Mental Retardation, Inebriacy boards. (See map on page 63.)

The Community Mental Health Centers Act initially envisioned an emphasis on direct clinical services to individuals and families with mental illness problems, but this emphasis has changed significantly over the subsequent years. The changes were caused by local circumstances as well as by nationally changing concepts and philosophies of care and treatment of persons with social-dysfunction problems. In Minnesota, the enabling legislation was reinterpreted, broadening the area of boards' responsibility to include the disabilities of mental retardation and inebriacy involving all chemicals.

Local boards are responsible for designing, developing, implementing, and evaluating comprehensive community-based programs for mental illness, mental retardation, and inebriety. This includes, but goes beyond:

1. The provision of direct services to individuals with problems;
2. Consultation work with other care-giving agencies; and
3. Helping the public welfare department with its statutory problems.

The local board can accomplish this by community organization efforts, by contracting with other providers or by serving as the community organization itself. The Directory of Minnesota Area Mental Health, Mental Retardation Programs for 1970-71 (compiled by the Minnesota Department of Public Welfare) shows the wide variety of developing patterns. Twin City area private mental-health centers under contracts with area mental-health, mental retardation, inebriacy boards have established the following affiliations: Hamm Memorial Clinic and Wilder Child Guidance with the St. Paul, Ramsey Area Board; the Minnetonka Mental Health Clinic, Washburn Child Guidance, Pilot City Mental Health Center, and Metropolitan Mental Health Center with the Hennepin County Area Board.

A variety of services are provided through the various facilities They cover diagnosis, evaluation, treatment, training in daily activities, specialized education, counseling, family counseling, and social casework. Staffs of the various centers include some or all of the following: psychiatrists, psychologists, social workers, nurses, therapists, special counselors, special education teachers, sociologists, biometricians, educational consultants, speech and hearing therapists, mental-retardation generalists, alcoholic and drug counselors, and pastoral counselors.

Administration of the law is assigned to the Department of Public Welfare, Medical Services Division, Community Programs Section. At this time, the Section staff consists of three professionals (one master's-level nurse, Section Director; one master's-level social worker; and one master's-level public-health administrator) and one secretary-receptionist. The Section's responsibilities include administration of the legislative appropriation for direct grants-in-aid, community consultation, and program consultation.

State staff works with local program boards in an effort to clarify roles, responsibilities and expectations between traditional care-giving agencies and the new centers and clinics. In addition, the Section administrates and provides consultation to federally funded mental-health projects.

The state hospital system is jointly administered by the Medical and Retardation Services Divisions. This is an important relationship for planning and coordination of residential and community outpatient services. At the local level, the area boards must relate to all those systems involved with the three disabilities, including county welfare departments, public schools, and the state hospital serving their area.

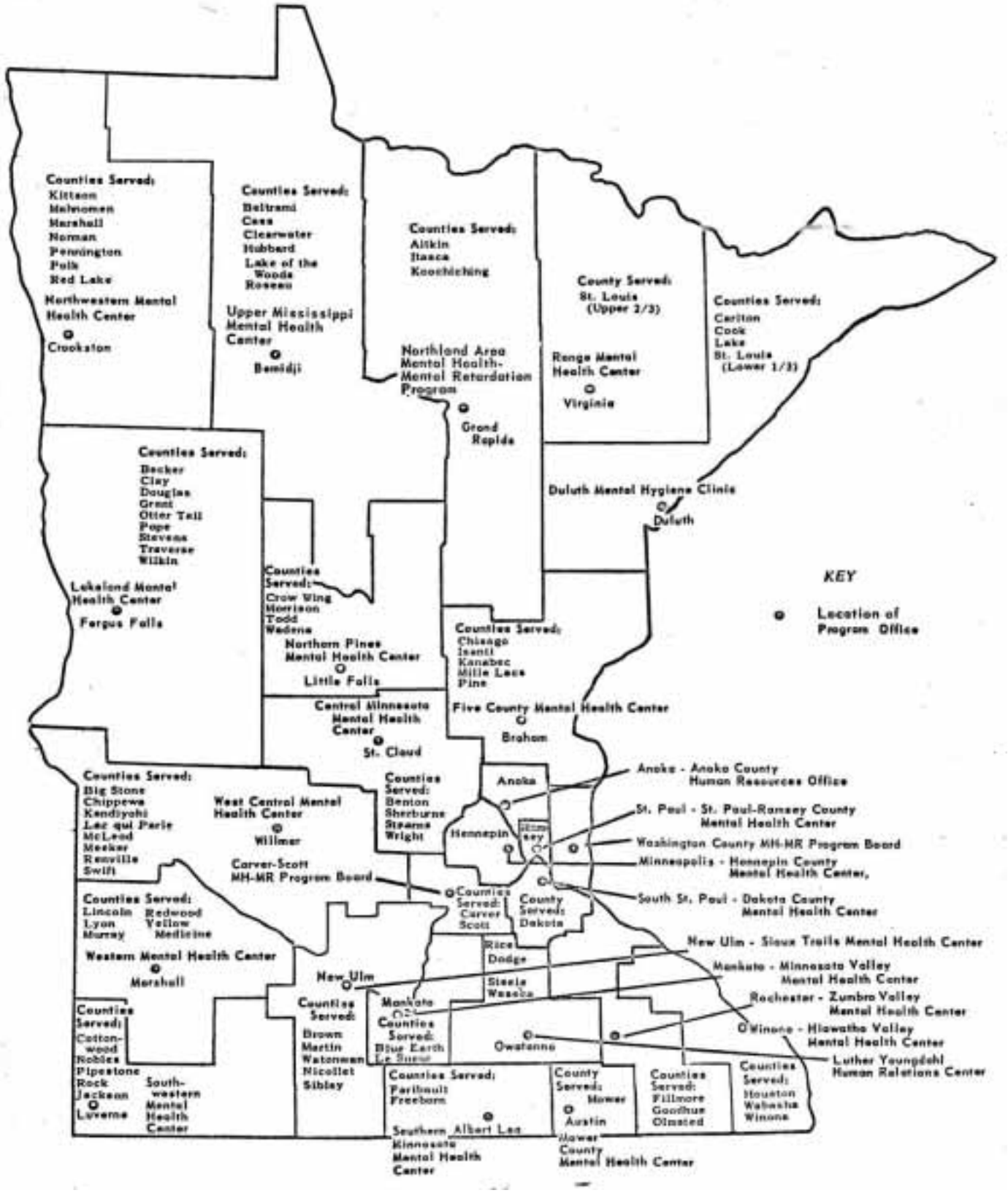
The funding plan for area boards include:

1. State grants-in-aid of up to 50% of center expenditures (certain economically distressed counties can receive up to 75%);
2. Authorization for county boards of commissioners to levy up to a two-mill tax;
3. Fees for service; and
4. Contracts for service.

The legislative grant-in-aid appropriation for this biennium is $8,500,000.

The last legislature also assigned to the area boards a more specific responsibility for development of a continuum of care for individuals with alcohol and drug-abuse problems. This statute, Chapter 892, is being administered by the State Planning Agency, Drug Abuse Section. The Legislature also passed a licensing law, Chapter 627, applying to inebriety and mental-illness facilities, which the Community Programs Section will administer.

MINNESOTA'S AREA MENTAL HEALTH-MENTAL RETARDATION PROGRAMS



Public Operations Office, Department of Public Welfare (serving both the Retardation and Medical Services Divisions)

The sole objective of the service, established in 1970, is advocacy for all persons with problems related to mental illness, mental retardation, and inebriacy. The office operates under the Mental Hospitalization Commitment Act.

Service is initiated whenever someone writes, phones, or walks in to lodge a complaint or discuss a difficulty. These are investigated to determine the real problem and the responsible state office. Attempts are made by the public-operations office personnel to solve the problem. This may take several forms. The conflict may involve differences of opinion between two government agencies regarding the best interests of the client. If the system actions have been inappropriate, the facility or facilities involved make changes in procedure in the interest of the client. If this does not resolve the difficulty, then compromise is attempted between client and the agency responsible for his welfare.

It is estimated that 10-20% of all clients have developmental disabilities. The total number of clients last year was about 1,000. All who requested services received some kind of help. No services are purchased. Clients are followed up once, after three months.

Referral services include the client him- or herself, county welfare departments, clients' families, state hospital residents or ex-patients, and the Governor's office. It is not known to what extent clients are involved in other agency programs.

Full-time staff includes two local case services specialists and one local case services supervisor, each of whom have master's degrees, and one director of the public operations with a Ph.D. Selection is made through Civil Service procedures.

Costs for review boards and special review boards are estimated to be less than $15,000 per year. Expenditures for personnel are limited to $50 per day, plus meals and travel. Funding is by state hospitals and is expected to be continued.

Family and Guardianship Services, Retardation Service Division, Department of Public Welfare

The program began in 1971. Its objectives are:

1. To assure compliance with policies and statutes of the program for mental retardation, primarily through county welfare boards;
2. To continue to develop policies for guardianship and for family involvement in decision-making for the mentally retarded;
3. To continue to work with the Department of Public Welfare Training Section to increase county welfare staff capabilities to carry out guardianship responsibilities;
4. To study other guardianship advocacy programs; and
5. To supply continuous, responsible governance for individuals who need it by reason of mental deficiency.

Minnesota law makes the Department of Public Welfare and county welfare boards generally responsible for the welfare of mentally deficient children. It also assigns lifetime guardianship of a mentally deficient person to the Commissioner of Public Welfare. This guardianship is given through the Probate Court, usually on the request of a relative, or of the county welfare board in cases of neglect or behavior dangerous to others and not controlled by the family. Persons may remain at home, be placed outside the home for special education or treatment, or be institutionalized. Last year there were 9,885 mentally retarded persons of all ages under guardianship. Another 500-600 clients were not placed under guardianship. Approximately 10,000 are expected to be under guardianship in the 1972 program. It is unknown how many persons could have been served.

Referrals to the program are from: county welfare agencies, state or private mental retardation facilities, physicians, school authorities, attorneys, law enforcement personnel, probate judges, citizens, or the inter-state mental-health compact administrator.

Extent of involvement of mental retardation in other programs is unknown but is expected to be modified by the Special Education Mandatory Trainable Law.

All of the services of the program — determination of need, arrangements for placement, family counseling — are provided by county welfare boards.

Criteria for judging success or failure are based on whether individuals are restored to maximum capacity and are discharged from guardianship. Clients are followed up and re-evaluated.

Two full-time professional persons serve the division office; other services are provided at county welfare offices as required. Staff members are selected on the basis of education, experience, and personal qualifications.

A program change for improvement of services would be the creation of regional family and guardianship staffs.

Day Activity Center Program, Retardation Services Division, Department of Public Welfare

The Day Activity Center program began in 1961. There are currently 113 licensed and 97 funded programs in 64 counties (see Appendix C). The objectives of the program are to maximize growth and development potential of individuals with mental retardation, cerebral palsy, and epilepsy; this is accomplished through education, social services, medical and psychological services, developmental programming, and parental counseling.

Day Activity Centers provide some or all of the following services: training in daily living skills, self-care skills, social adjustment skills, functional-level education, language development, prevocational training and adjustment, parental counseling, and work activities. Purchased services are: psychological evaluation, speech therapy, and physical therapy. Referred services are: medical services, social-casework services, and psychotherapy or personal counseling.

These services are available to everyone in the program. However, about 25% of the applicants do not receive them because some centers do not yet have all of the services, they are not conveniently accessible, or the service is refused by the parent.

Service needs are professionally determined. Two hundred ninety-two applicants requested but did not receive service this past year. The total number served in the last fiscal year was approximately 2,400 persons with mental retardation, cerebral palsy and epilepsy. Ages ranged from four to 65 years. Severity of the disability ranged from "greatly affected" to "educable."

The licensed day-activity-center capacity in Minnesota is for 2,123 individuals.

Multiple handicaps are recorded separately in the client's record at each day care center.

Referrals to the centers are from parents, county welfare, associations for retarded children, mental health centers, schools, the Cerebral Palsy Association, state hospitals, physicians, and crippled children's services.

Developmentally disabled persons in the program are also involved in other programs. All are receiving medical and related services. It is estimated that 20% are also receiving welfare services, 2% are receiving employment services, and 2% are receiving Division of Vocational Rehabilitation services. Minnesota's new Mandatory Trainable Law is expected to add about 4% new special education clients, and a projected increase in cooperative agreements with sheltered workshops would add another 2% to their present load.

The board of directors at each center selects its own staff. The staff that provides indirect client services consists of 40 administrators, ten janitorial, and ten clerical employees. Direct client services are provided by 99 directors, required to have a B.A. level of education or its equivalent; 271 teachers, all of whom have a B.A. degree or some college; 153 aides; and 17 bus drivers. (There are no educational requirements for teachers, aides, or bus drivers.) Hundreds of volunteers provide thousands of unpaid man-hours to the day-care programs. There are two Mental Retardation Program Consultants, one Day Activity Center Funding Director, and one half-time clerical person in this program at the state office.

This is a grants-in-aid program; state-spending is limited this year to $1,400,000; the local share is $2,335,168. The state's share in 1972-73 is expected to be $1,500,000. All of the funds

are spent to provide services. The state matches local expenditures at 60% maximum, except in the case of distressed counties, which may be matched at 75%. At present the state is matching local expenditures at about 42% because the request exceed the available money. Guidelines to facilitate distribution are being developed. Some federal monies are expected to be available for program expansion.

Programs are evaluated by judging the personal growth and development of individuals served at the centers. Success in helping persons achieve program objectives is estimated to be about 75% of those receiving services. Dropout is about 5%. Follow-up is informal.

No cost/benefit information is available; however, the amount (average) spent per person is small compared to the expected benefits.

If more money could become available, services would be expanded. Staff increases recommended are for statewide positions: four more Mental Retardation Program Specialists and one clerk. Staff increases at centers would be for teachers and aides. All services should be expanded, but priority should be given to preschool training, post-school work activity, physical and speech therapies. A building program is needed; activities are housed in every imaginable type of structure.

Cost of Boarding Care Outside of Home and State Institutions, Retardation Services Division, Department of Public Welfare

The program began July 1, 1969. Minnesota Statutes, Section 252.27, provides a plan for States participation in residential and program services costs. This plan is intended to assist parents and welfare departments in paying for placement on the basis of the residential and program services needed. The program is administered through county welfare boards. Its objectives are:

1. To provide a wide variety of private boarding facilities for the mentally retarded and epileptic;
2. To provide financial relief to parents whose children are placed in private boarding facilities; and
3. To assist county welfare departments in paying for private boarding facilities.

An appropriate program and placement plan is developed for each retarded child by the county welfare department, in cooperation with the parents. This plan should be reviewed and updated annually.

The program is for mentally retarded and epileptic children younger than 18 who live in Minnesota or are children of Minnesota residents, The child must have had a psychological examination within three years of application. The boarding facility must be licensed or, if out-of-state, approved by Retardation Services Division. (Some very good out-of-state facilities are not licensed.) The written plan for each child must be reviewed annually.

A total of 764 mentally retarded children were served in the 1971 fiscal year. Some were multiply handicapped. It is not known if others eligible did not apply, but all counties that applied for

state reimbursement were honored. No records of source of referral are kept, but cases are thought to have come, most often, from parents and county welfare workers.

The program is developed by the county in cooperation with the parents. Written developmental plans are stored at the county welfare offices; therefore, the information contained in them is not immediately available to the state office.

Placement facilities for the children range from foster homes to very specialized schools. Needed services may be purchased from outside the facility. The county is required to place each child in a facility that agrees to meet all of his individual needs as prescribed in the written plan.

No adequate system exists for evaluating the written plans of facilities. It has been assumed that the safeguards of requiring placement in approved facilities, written plans, and child evaluations will assure some acceptable quality of service. The Retardation Services Division is attempting to develop a system for ensuring quality of service, especially through its licensing program. Written plans are to be reviewed annually by the county welfare departments; but since the review is uneven, all children may not receive annual follow-up.

The cost-of-care program is staffed by one half-time coordinator. The county pays—100~~%~~ *of the* care. The state reimbursement to the county welfare departments can be up to 50% and the parents, if able, are required to reimburse 10%. The parents may voluntarily contribute more if they wish. Costs for individuals range from $90 to as much as $800 per month. State funds for the program amount to a total of $1,122,460 ($22,460 for salaries and $1,100,000 for care); county funds amount to $1,100,000 (for care). State funds are expected to increase to $1,280,000 and others to $1,250,000. The child's home school district may assume some of the costs.

Regional Centers for the Retarded (State Institutions), Retardation Services Division, Department of Welfare

The state institutions at Faribault and Cambridge were the only-major state resources for the retarded until the institution at Brainerd was established in 1959. Since then, and partially because of a legislative mandate to regionalize the Department of Welfare services for the retarded, some major steps have been taken to diversify the retarded populations and to serve them closer to their homes. A variety of programs and services have been established.

The present centers are located at:

Faribault State Hospital;
Cambridge State Hospital;
Minnesota Learning Center, Brainerd;
Lake Owasso Children's Home, St. Paul;
Mental Retardation Unit at Fergus Falls State Hospital;
Rochester Social Adaptation Center;
Minnesota Valley Social Adaptation Center, St. Peter;
Mental Retardation Unit at Moose Lake State Hospital;
Mental Retardation Unit at Hastings State Hospital.

The Retardation Services Division has called a halt to further establishment of units in other state institutions until a state-wide plan is established in the division and linked with other agencies and groups on a county-area-regional-state basis. It is in this context that the Retardation Services Division plan has been developed. Copies of this plan have been made available to Advisory Council members by the Retardation Services Division.

The average total population at these centers is 4,200 mentally retarded residents; they represent 60% of the state institution population.

It is estimated the approximately half of these residents could benefit from other more suitable programs and services in their own communities if they were available. The regional centers could then concentrate on the remaining half for purposes of training, physical rehabilitation and socialization in preparation for community living.

This population includes the retarded of all ages, both sexes, all types and ranges of severity of disability categories.

The divisional goals of these centers are:

1. To establish all centers as developmental training centers;
2. To establish clearly defined health services within each center;
3. To assess the abilities of each resident individually and develop training and treatment plans to reduce dependency; and
4. To establish program goals for each program unit in the center in measurable terms.

Program units are organized in each center to link together the major service areas (medical, educational, vocational, social, personal, recreational, and so on). Each unit has a full-time program director who is responsible for assessing individual needs (with such instruments as the Adaptive Behavior Scale) and organizing services in such a way as to bear directly on the problems of the individuals in his unit. Program units vary in size depending on type of residents and the nature of their abilities. Each unit is responsible for developing and delivering individualized programs. The units are now in varying stages of development.

Historically, program evaluation has been measured by the number of residents, their length of stay, the numbers and level of

training of staff members and so on. Plans are being developed to evaluate program success or failure on the basis of change in measurable behavior. There is no Cost/benefit information.

County welfare boards have both referral and follow-along responsibilities. There is much variation in the way these are carried out.

Federal funds that reimburse the state in part for this program are placed in the state general revenue fund and program expenses are placed against the state budget.

The programs at Faribault, Brainerd, and Cambridge are funded as follows: federal, $7,511,000 (cost of care paid through the Aid to the Disabled Program); state, $19,500,000 (net operating cost); and other, $67,000. The expected follow-up level of funding is: federal, $7,700,000; state, $21,000; and other, $70,000. A total reduction of 545 positions in all state institutions means a staff cut of approximately 327 positions for these centers.

Mental Retardation Licensing, Retardation Services Division, Department of Public Welfare

The program for licensing residences for the mentally retarded was initiated at the beginning of the fiscal year 1972 through the enactment of Minnesota Statute 252.28. Under this program, the institutional concept is to be minimized, with main emphasis on separate residential facilities in a community that also provides sheltered workshops, daytime activity centers, and other community-based services. Only where individual needs cannot be met through such services would the residence also he expected to provide such services as vocational counseling, training in self-care skills, or orientation to the community.

The licensing procedure is to establish a system of quality control for residences beyond safety, nutrition, etc. It includes consideration of programs developed around individual assessment and service plans. Individual programs are to be required to meet individual needs.

An advisory board on mental retardation licensing, appointed by the Commissioner of the Department of Public Welfare, is in the process of formulating standard rules. Using the rules as guidelines, the board will oversee the licensing process to assure that quality service is given to mentally retarded persons. The rules will apply to private and public residential and day care facilities and services for mentally retarded persons. Licenses will be renewed annually. The advisory board may also assist the Commissioner of Public Welfare in consideration of social, medical, educational management, parental, and community interests of the retarded person.

Criteria for judging the success of the licensing standards and of their enforcement involve:

- the degree to which facilities and services meet standards;
- the degree to which facilities and services are able to define their purpose relative to individual mentally retarded persons' needs, and relative to other generic and special facilities and services;
- the degree to which licensure is a means of implementing regional planning, rather than a response to the present structure of services.

For a review of Minnesota residential facilities for the retarded, see Appendix D.

3.2 Department of Health

Unit of Maternal and Child Health and Division of Administrative Services, Section of Nursing, Division of Special Services

Follow-Up of High-Risk Mothers and Infants (Medical Supplement to the Birth Certificate)

A pilot project in Hennepin and Anoka Counties, to follow up all high-risk infants and mothers, was started in January, 1971. The goal of this program is to reduce mortality and family health problems by improving the physical, social, and mental well-being of mothers, infants, and other family members. This became possible through the use of data from the medical supplement attachment to the birth certificate identifying high-risk mothers and infants, particularly those with congenital malformations or serious birth injuries. Follow-up is done by public health nurses, who must first obtain permission from family physicians for the visit and then submit reports of visits to them indicating services rendered and any family problems with health implications of interest to the physicians. This pilot project is expected to expand gradually to cover the state.

All mothers and infants identified as high-risk by the state health department receive at least one visit from a public health nurse after bringing their newborn babies home from the hospital. Parents have asked for health education and counseling about infant care, such as feeding, diaper rash, and bathing; growth and development, emotional acceptance, and adjustment to the infant within the family constellation; and acceptance of infants with handicapping conditions. Emotionally supportive health counseling is offered to families. Encouragement is offered to assist them in following through with physicians' recommendations and to seek medical attention when necessary. Continued service is often requested concerning health-related needs of other family members.

The use of the high-risk selection criteria resulted in the referral of 602 families to local nursing agencies during the study period of January 1, 1971, to April 15, 1971.

Of the 477 referral reports returned to the health department, 417 (87.4%) nursing contacts were made either by telephone or a home visit. Continued nursing services were found to be needed in 174 families, representing over one third of the families referred. Of the 174 families needing continued services, 83 families were already known to the nursing agency, and 91 families were accepted for service for the first time as a result of these referrals.

The criteria for identification of high-risk infants and mothers are: prematurely; hereditary or familial tendencies; low birth weight; large infants; frequent pregnancies; previous fetal deaths; mother under age 17 or over 40 years with no prenatal care; mother with diseases such as rubella during first trimester; diabetes, toxemia, or hydramnios, tuberculosis, cardiac conditions, Rh incompatibility, urinary tract infection, and major surgery during pregnancy; or prolonged labor.

This pilot program, which is attempting to further define high-risk criteria, has developed from the congenial malformation follow-up program, which has operated since the fall of 1969. Fifty-three counties are covered by public health nurses. The remaining counties are covered by the three maternal- and child-health nursing consultants during visits to these areas.

Cytogenics Laboratory Unit and Phenylketonuria Laboratory Program (Division of Medical Laboratories) Human Genetics Unit (Division of Special Services) Department of Health

Phenylketonuria Laboratory Service Program (Division of Medical Laboratories)

This testing service is provided as an aid in the prevention of mental retardation and in fulfillment of a state law requiring that all newborn infants be tested for aberrant phenylalanine metabolism. The laboratory test of blood and urine samples submitted to the laboratory determines the metabolic anomalies, particularly phenylketonuria (PKU), in newborn infants. Specimens for examination are received from physicians, clinics, and hospitals. Reports are sent to the submitting hospital, physicians, and clinic. Copies of all positive and doubtful reports are sent to the section of maternal and child health for follow-up.

During the past fiscal year 70,000 tests were run and six cases of phenylketonuria were confirmed. According to an article in Inquiry (September 1971) by John Gentry, the cost of PKU testing is 18 cents per child. Treatment through the use of a special diet permits the child to achieve a more normal development. Untreated children develop severe mental retardation. In 1966, estimates of the cost of the special diet were $1,200 per year and a total cost for lifetime institutionalization totaled $250,000 per child. Thus estimated saving by prevention is up to $25 for each $1 invested.

The expenditures from July 1, 1970 to March 31, 1971, show $6,744.00 in federal maternal- and child-health "A" monies and $11,020.45 in state monies.

Cytogenetics Laboratory Unit (Division of Medical Laboratories)

Blood specimens are submitted to the laboratory from doctors' offices, hospitals, and clinics for chromosome analysis. Certain

cells are selected and grown, using tissue culture methods. At the appropriate time the cells are examined microscopically and fields showing good distribution of chromosomes are photographed. The individually photographed chromosomes are cut out of the photograph, paired, and mounted on a sheet of paper. The material is now ready for Karyotyping, a process through which chromosome-abnormalities can be identified. The entire procedure is tedious; currently the laboratory can process four to six specimens per week. The laboratory results are sent to the Human Genetics Unit (Division of Special Services) for final examination.

During fiscal year 1971, the cytogenetics laboratory received 219 referrals for chromosome analysis, of which 80, or 37%, were determined to have abnormalities. Of these referrals, 47% came from out-state physicians and agencies.

In a study of 100 mentally retarded cases serviced between November, 1970, and November, 1971, 76 were referred for chromosomal abnormalities, of which 47 were confirmed and 24 were found to have idiopathic mental retardation.

70 suspected	Down's Syndrome	44 confirmed
2 suspected	Trisomy D	2 confirmed
4 suspected	Trisomy E	1 confirmed

The expenditures from July 1, 1970,to March 31, 1971, show $15,874.61 in federal maternal- and child-health "B" moneys and $8,655.07 in state monies.

Human Genetics Unit (Division of Special Services) The Human Genetics Unit provides counseling to patients and their families upon referral from the family physician, the Department of Welfare, the Dight Institute, or other state institutions,

when there is a suspicion of a hereditary problem from the patient's history or test results. The genetic counseling program, which was the first in any state health department, began in 1961. Services were provided for 153 patients from all over the state during fiscal year 1971.

The Cytogenetics program screens all patients referred for cytogenetic evaluation and arranges appointments through the referring source when a patient has been accepted. The specimen is submitted to the Cytogenetics Laboratory Unit for processing and their results are sent to the Human Genetics Unit for final evaluation and diagnosis. The Human Genetics Unit then sends a written report to the referring physician or agency and provides direct patient counseling when requested. Recommendations for additional studies, when indicated, are made at this time. All records are maintained by the Human Genetics Unit.

A laboratory charge to the patient is made on the family physician's declaration that the family can afford the charge. No laboratory charge is made if the referral is initiated by the Department of Welfare, a state institution, or the Crippled Children's Services.

A new program providing diagnostic services for inborn errors of metabolism and other biochemical caused diseases has been initiated within the Human Genetics Unit. This service, to define many diseases which involve mental retardation, is available upon physician or health-agency referral at no charge to the patient or family.

The expenditure from July, 1970,to March 31, 1971, shows $21,890.81 in federal maternal- and child-health "B" monies and $14,119.03 in state monies.

Child Development Center, Fergus Falls, Division of Special Services, Department of Health

This program began in 1957; it is cosponsored by the Department of Public Welfare. The Child Development Center is a division of the Lakeland Mental Health Center and serves nine counties. It is an evaluation center for children under 21 who are suspected of being mentally retarded. In addition to evaluation and diagnosis, the center staff develops plans for care and treatment and provides specialized education when necessary. Attempts are being made to have all physicians in the area notify the center of impending high-risk births, so that parents may be informed of the services available, and so that the newborn child can be evaluated and receive whatever special care is necessary.

Families with mentally retarded children are contacted by a public health nurse who explains the program and makes arrangements for a medical examination. She will carry out follow-up instructions in medical and nursing areas, serve as a consultant to the district public health nurse, and teach the family how to care for individual children. The social worker coordinates services through liaison with other agencies and counsels the family. Complete diagnostic services for all children in the program are available through the Lakeland Mental Health Center. All children are periodically followed up and re-evaluated.

The total number served during the last fiscal year was 383; ages ranged from infancy through 20. Two hundred forty-two new applications were received during the year ending June 30, 1971, from which services were initiated for 171 children, all mentally retarded and some multiply handicapped. Fifty were withdrawn and 21 remain on a waiting status.

The full-time equivalent staff members are: a program director (also administrator), one medical director, one pediatrician, three clinical psychologists, three school psychologists, four psychiatric social workers, one public health nurse, one speech therapist, and one pathologist. Psychiatrist time is equivalent to 1 1/2 full-time persons. In addition, two public health nurses and one speech and hearing consultant are provided by the Maternal and Child Health division of the Health Department.

Federal funding in the amount of $68,000 supports the center. Federal funding will be cut this next fiscal year. This cut is expected to be reflected in a cut in services from the State Health Department.

The program is advised by state and local advisory boards. The state board approves plans and makes major policy changes. It has representatives from the state departments of Health, Education, and Welfare, the University of Minnesota, MARC, Crippled Children's Services, and the State Medical Association.

The county advisory boards are local inter agency committees on mental retardation. They are composed of representatives of the state departments of Health, Education, Welfare, state institutions, local school administrators, county welfare executives, county public health nurses, executive secretaries of the county board, and the local MARC chapter.

Child Study Center, Owatonna, Division of Special Services, Department of Health

The program that serves Dodge, Rice, Steele, and Waseca counties was begun in 1964 as an extension of the pilot program at Fergus Falls. It is cosponsored by the Department of Public Welfare. The program objectives are:

1. To demonstrate further what can be developed in rural counties as part of the responsibility of the community to improve local services for the mentally retarded by:
   - finding retarded children under the age of 10 years in a designated four-county area,
   - providing adequate diagnosis and evaluation and secure treatment where indicated,
   - providing or securing extended counseling,
   - demonstrating to what extent local organizations may be established and how they may work with retarded children in a rural area.
2. To stimulate and foster the development and operation of community services for retarded children and their families by:
   - demonstrating the variety of facilities and services that may be set up and made available on a regional basis,
   - providing further information on the type of activities that can be organized and carried on by local communities in a rural setting.
3. To demonstrate the necessity and value of specialized diagnostic services in multi-county or readily accessible regional areas in evaluating retarded children and related handicapping conditions.
4. To reduce the need for institutional care by early and complete evaluation and the provision for local health, educational, and community services.

According to the evaluation report for the year ending June, 1971, there were a total of 141 applications, and services were initiated for 111 persons. Fifteen remain on a waiting list and 15 others were withdrawn. Service was given to a total of 210 children.

Referrals are most often through schools and Head Start programs, but formal referral by the family physician is encouraged. During the last four months of 1970, a social worker and two public health nurses spent a considerable amount of time making contact with preschool programs such as nursery schools and Head Start programs. As a result, more referrals are being received for younger children. The schools continue to refer children, many from parochial schools where there are no school psychologist services. Also, physicians in the area who utilize the services of the center are referring children at an earlier age. Because of the resulting increase in service load, the center has made more referrals to other agencies, preschool day activity centers, nursery schools, and Head Start programs for certain services needed by the children. In 1970 the Rice County Day Activity Center started a limited preschool program for five severely retarded children referred by the center. This program should enable some of these children, after a sufficient period of training, to attend the class for trainable children in the public school system.

Services in the program are provided free of charge. The services are evaluation, diagnosis, treatment, extended counseling, and periodic follow-up. In a special follow-up study conducted in 1965-66, of the first 100 children evaluated at the Center, 59 were found to be still active with the center; 76 of these 100 were found to be retarded; 64 of these continue to live in either their own homes, homes of relatives, or foster homes. Only 12 of the children are in institutions.

The staff members include a medical director, a psychologist, and associate director, a case worker, two part-time public health nurses, and a speech therapist. One public health nurse handles the caseload in Waseca and Rice counties and the other handles the public health nursing caseload in Steele and Dodge counties. The speech therapist handles mostly preschool children because most of the school children who have been referred to the center have been seen by speech therapists in their schools.

Funding from the Children's Bureau Project is $60,000 per year. A cut in the Children's Bureau funds for this next fiscal year will probably mean a cut in services.

3.3 Department of Education

Special Education Section

In the Department of Education, the Special Education Section, a subdivision of the Division of Vocational Rehabilitation and Special Education, coordinates the special education programs in the public school districts throughout the state. Special Education services are provided for handicapped children who need special services to supplement or take the place of regular classroom instruction. The Section disburses a variety of federal and state aids to individual districts and inter district cooperatives for staff, materials, and special transportation.

Special Education uses the seven planning regions of the state and has six regional supervisors for the non-metropolitan regions. Half of the school districts in the state are covered by special education programs that have recognized administrators. Many of the other districts have special education services in their schools; the Special Education Sections contacts these districts through individual supervisors, school principals, counselors, or teachers.

Federal assistance totaling approximately $2,400,000 comes to Minnesota for special education under several pieces of federal legislation. Some of these programs are administered by Special Education and others by the Planning and Development Section and by the Administration Division. An additional $600,000 comes to Minnesota for services to the Division of Vocational-Technical Education. Most of the approximately $620,000 of federal funds are used to support cooperative leadership projects where three or more school districts share

a director of special education who helps develop and expand educational services for handicapped children. This legislation also supports the regional special consultants in six of the seven regions of the state and special projects for the severely retarded and preschool programs for the hearing impaired.

The bulk of special education services are provided in regular school districts throughout the state. In addition, there are special programs in the six institutions for the retarded and blind that are operated by the Department of Public Welfare at Brainerd, Faribault, Lake Owasso. Cambridge, the School for - the Deaf, and the Braille School,

During the 1971-72 school year, it is estimated that approximately 73,500 handicapped children will be served. Of this total, the mentally retarded and children with learning disabilities account for about 37%, or 27,000 children. Children with cerebral palsy and epilepsy are not separately categorized and would be among the 840 children listed as either "crippled" or "other health impaired."

The Section estimates that this year a total of an additional 52,000 handicapped children need Special Education services but will not receive them. In this total are included about 2,100 trainable mentally retarded, 7,600 educable mentally retarded, and 12,300 children who have learning disabilities -- a total of about 22,000 developmentally disabled children. These estimates are based on the difference between the actual number of children being served and estimated incidence rates for various disability groups among the school-age population The estimates of incidence that are used are as follows: trainable mentally retarded, .45%; educable mentally retarded, 1.6%; learning disabled, 2%. These incidence rates have already had

subtracted from them the percentage of children served in residential facilities and other institutions.

The most significant recent change that would affect these numbers of children getting and needing services is the legislation requiring _the provision of services to the trainable mentally retarded. This could triple the number of such children served, ft currently is about 3,300 and within a year this could increase to as many as 10,000. Programs for special learning and behavior problems (SLBP) are expected to continue to grow with the growing recognition of need. Approximately 12,000 such children are being served by special education this year and this number is expected to increase to at least 15,000 next year.

More detailed information on the characteristics, need, level of disability, and so on, of children receiving special education services is available in some local schools and some local_school districts. However, there is no mechanism for combining and collecting this information on a statewide basis.

At the state level, the only information that is available now for evaluation purposes is overall numbers of children in various disability groups being served. The Section is working to help local districts develop skills in setting objectives and evaluation programs, but there is not yet a statewide system for accomplishing these aims. The Section is also trying to get complete needs assessment in the districts. One region has done such a needs assessment, and it is expected that all regions should complete theirs in three years. One of the prime efforts of the unit is to develop better methods of evaluation. Comprehensive objectives for special education were set last year, and this year objectives and evaluation

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stems of several districts are being reviewed. The Section is also moving toward comparable evaluation schemes and monitoring systems. The development of cost/benefit information depends on the development of both measures of effectiveness and comparable methods of determining costs throughout the state.

The Special Education Section has a total of 25 staff members. The director has an assistant in charge of administration (who has a total staff of nine, including seven clerical personnel) and an assistant in charge of program (who has eight consultants and six regional staff persons).

Within the Department of Education some consideration is being given to relocating Special Education outside of the Division of Vocational Rehabilitation. If this is done, the staffing of the Section would probably also be affected.

It is difficult to determine the total amount of money spent within the state of Minnesota for special education services. For the current school year, however, approximately $2,400,000 of federal money is coming into the state, and approximately $19,000,000 in various state aids fund is being provided. It is expected that this level of funding will continue in the near future.

If more money were available, the Section would do a number of things: (a) More money and services are needed in the area of preschool children. Provision of such services now is optional and, consequently, is being provided in very few districts. (b) Additional services are needed for severely handicapped children, such as the deaf-blind, autistic children, and others with severe emotional handicaps, (c) Better coordination of current services is needed. (d) Vocational education for the

handicapped should be expanded, (e) Services to parents of handicapped children are needed to supplement the services provided in schools, (f) More complete needs assessment throughout the state are needed for planning purposes, (g) Additional training, not only of special education teachers, but of all teachers, is needed to equip them better to serve handicapped children.

Division of Vocational Rehabilitation, Department of Education

The program has been in operation since 1921. Its broad objective is to provide goods and services that develop the ability of physically and mentally disabled persons to attain as productive a life as their capabilities will permit.

The program's specific objectives are:

1. To reduce the backlog of persons needing service by 9% in fiscal year 1973, 13% in fiscal year 1974, and eliminate the total backlog by the end of fiscal year 1975.
2. To serve 100% of the school-age population needing service by 1975.
3. To increase the number of persons accepted for rehabilitation.
4. To provide rehabilitation at the earliest possible time after the onset of the disabling condition.
5. To reduce the length of time persons referred to the program spend in pre service status (from referral to notification of eligibility).
6. To reduce the number of persons who spend 90 days or more between referral and eligibility notification.
7. Follow-up and analyze rejected, non-eligible, or dropout (after application) cases.

Eligibility for the program is determined by the Division of Vocational Rehabilitation by:

1. The presence of a physical or mental disability (a physical or mental condition that materially limits, contributes to limiting, or if not corrected will probably limit an individual's activities or functioning).
2. The existence of a substantial handicap to employment.
3. A reasonable expectation that reasonable vocational services may render the individual fit to engage in a gainful occupation.

The Division of Vocational Rehabilitation records up to three disabilities in the case of multiple handicaps.

The total of clients served last year:

All: 35,145;

Identified disabilities: 22,462;

Last year -- mental retardation, cerebral palsy, epilepsy, other: 7,177 (identified);

This year -- mental retardation, cerebral palsy, epilepsy, other: 7,500 (identified).

The total number of persons with identified disabilities who requested service but did not receive services was 496; of these, 249 were developmentally disabled (4.8%, mental retardation; 4.2%, cerebral palsy; 7.8%, epilepsy; 8.5%, other). Rene V. Dawis's "Estimates of Disability in Minnesota" states that 4,000 more could benefit from vocational rehabilitation.

Most frequently referrals to the program come from educational institutions, hospitals, state institutions, and individuals.

Involvement of Division of Vocational Rehabilitation clients in sheltered workshop programs may be decreased by a pilot program of six work-activity projects. The work activity is to fill gaps between day activity and sheltered work. Vocational Education, Special Education, the Division of Vocational Rehabilitation of the Department of Education, and the Department of Public Welfare are cooperating on the project.

Clients in the Division of Vocational Rehabilitation are given all services recommended by a counselor's diagnosis of need. The services available in the program are:

- diagnostic services and related services (including transportation) required for determination of eligibility and the nature and scope of services to be provided;
- counseling, vocational;
- physical restoration services;
- training;
- books, materials, supplies;
- transportation;
- occupational licenses;
- interpreter services for the deaf;
- hospitalization and surgery;
- other goods and services necessary to render a handicapped person fit to engage in a gainful occupation;
- placement.

The Division of Vocational Rehabilitation has cooperative agreements with public school districts, the Department of Manpower Services, the Department of Public Welfare (blind and handicapped clients), and Crippled Children's Service.

The Division of Vocational Rehabilitation and the Vocational-Education Division are developing a cooperative service agreement. The agreements state separate duties and responsibilities and division of responsibilities in overlapping areas.

All parts of the program are funded by federal and state funds.

Students are re-evaluated throughout the program.

Success of the program is judged by whether or not graduates remain on a job thirty or more days.

Staff members are selected on the basis of Civil Service procedures.

Current full-time equivalent staff are as follows:

42.0	Vocational Adjustment Counselor	Master's degree
6.2	Cooperative Vocational Rehabilitation Program -- Rehabilitation Counselor	Bachelor's degree
1.4	Cooperative Vocational Rehabilitation Program -- Work Evaluator	Bachelor's degree
21.2	Cooperative Vocational Rehabilitation Program -- Work Evaluator	Bachelor's degree
1.0	Special Project Counselor	Bachelor's degree
3.0	Cooperative Vocational Rehabilitation Program -- Special Teacher	Master's degree

A new staff person, titled a "Planner - I," will be added to coordinate the new Work Activity Center program. .....

Increases in funds would be used to increase personal services (transportation, residency accommodations, more recreation facilities); to support long-term sheltered-workshop concepts; for new work-activity centers; for further expansion of the cooperative school-rehabilitation-center concept on state-wide basis; to support preschool education; and to provide more support for vocationally oriented programs in schools for children who have developmental disabilities.

Division of Vocational-Technical Education, Department of Education

The program began in 1946. The division office administers, coordinates, directs, and supervises a total of 387 state vocational programs. Through the division program, students under 14 are beginning to be introduced to their future role as employed persons. Actual vocational education or training may begin in grade nine. There are no criteria, as such, for acceptability to state vocational-training programs. The state programs are planned to train persons age 14 and older. About 20% of high-school students prepare for college, and 18% complete vocational-technical training in high school; this means that more that 50% of high-school graduates must find jobs without special or post-secondary training.

Objectives of the state vocational-technical education program are:

- Elementary-Secondary Level: orientation, exploration, job proficiency.
- Post-Secondary Level: job proficiency training.
- Adult Level: The objective for updating, upgrading, and retraining handicapped students is to increase enrollment by 105% by 1976 and to continue and expand inter agency planning and coordination of the services provided for the handicapped. One of the coordinated services is the Division of Vocational Rehabilitation, which provides for physical restoration, workshop activity, and sheltered-workshops training. The overall objectives of the program are to recruit, to provide life support, to develop and to maintain occupational competence and placement in areas and types of occupations in which employment opportunities exist.

Of the vocational education enrollment in school-year 1970-71, 5,800 were considered handicapped; 80%, or 4,640, of the handicapped were mentally retarded. This fiscal year there are 6,785 handicapped persons enrolled in secondary, post-secondary, and adult programs in all types of institutions (secondary vocational centers, secondary schools, junior colleges or community colleges, secondary-post-secondary combined, college or university, other public institutions).

No figures are available on the number of developmentally disabled. The division does not distinguish among kinds of reasons for learning deficit.

All who requested training were placed in training programs. The estimated number who could be helped (no figure on developmentally disabled) is about 10% of the total school population. The most frequent sources of referrals are the Division of Vocational Rehabilitation and school counselors.

The developmentally disabled in the program are also involved with the following other programs:

(Estimated) 50% with Division of Vocational Rehabilitation — cooperative agreement;

50% with Employment Service;

10% with Welfare;

10% with Special Education;

5% with day- or work-activity programs.

Services provided are training for a vocation and general education. Guidance counseling is furnished. During fiscal year 1971, 53 programs operated that were supported by funds set aside for handicapped persons. The programs will be continued

and others added (updating, upgrading, retraining of employed). The continuing programs are largely programs designed to meet the occupational training needs of handicapped persons and to prepare them for employment.

The criterion for success has been whether students obtain or are unable to obtain employment after training. Students and their employers are followed up one year after graduation or completion, and a portion of the graduates are followed at three- and five-year intervals. Ninety percent go into the field of their training (5% to 7% marriage loss). About 11% of total enrolled students are dropouts. Self evaluation is being conducted at the 31 operating area vocational-technical schools. Expert committees will conduct on-the-site evaluation in five post-secondary, 14 Junior Colleges, and 18 secondary centers. An evaluation system project is in progress. The eventual system will be a computer-assisted program of information and evaluation.

Title I - ESEA, Assistance for Educationally Deprived Children, Division of Administration, Department of Education

Title I programs are aimed at educationally disadvantaged children -- those achieving one or more years below grade level. In Minnesota this provides programs for approximately 2,000 handicapped children in 18 residential institutions, 700 delinquent children in correctional institutions, migratory children, and 60,000 children in local districts during the regular school year and 6,000 children in summer school.

In the past, Title I funds have been used to set up classes for the mentally retarded in schools. Next year it is expected that support under Title I may be reduced for mental retardation programs, since it is expected that regular state programs will provide for them.

During the current year $890,000 is being used to support educational programs for handicapped, retarded, emotionally disturbed, blind, and deaf children; and $3,000,000 is spent for these children in local school districts. It is not known exactly how many are developmentally disabled, although about 2,500 are mentally retarded. While most money goes to programs for school-age children, a growing priority is to serve preschool children.

The program is operated out of the state office with four regional offices in St. Paul, Bemidji, Brainerd, and Slayton. There are a total of 16 full-time equivalent staff members administering this program.

Title III - ESEA, Innovation Section, Division of Planning and Development, Department of Education

Title III, Programs to Advance Creativity in Education (PACE), provides for the creation, practice, evaluation, and dissemination of new ideas and ideals in the classroom. A diversity of PACE services throughout the state experiments and develops model programs for eventual state-wide use. These programs are funded separately for specified lengths of time.

The general goals of PACE projects related to developmental disabilities include:

1. Early identification of learning disabilities;
2. Development of educational services to meet specific needs;
3. Identification and trial of new learning situations;
4. Maximization of appropriateness of activity and resources
5. Dissemination of exemplary and innovative action;
6. Development of special education related to self-development and self-understanding;
7. Assistance to teachers;
8. Assistance to students by individualized instruction, counseling, job placement, and follow-up;
9. Development of a regional model for educational data processing that will enhance the future development of a state system.

Services involve children of preschool age through the secondary level of education at public and private schools. Several programs are specifically designed to create better learning conditions and other life influences for learning-disabled children. Typical programs are included in the following descriptions .

The Supplementary Educational Service Centers for Special Learning Disabilities program includes diagnosis of problems, prescription for treatment, clinical services, recommendation for educational programming, and referral. Eighty-eight school districts and associate member schools participate in a 24-county area in southwest and west-central Minnesota and are served by five centers.

The Psychological Service Center at Winona State College serves a six-county areas, offering special services designed to help elementary school children overcome speech, emotional, and learning problems. Winona schools and about 100 other schools participate.

The Work Opportunity Center in Minneapolis, participated in by Special School District #1 of the Minneapolis Public Schools, provides short-term skill training, job preparation, and instruction leading toward full-time employment or school reentry for school dropouts. The program has a significant outreach program. Skilled training is provided to handicapped children from the Special Learning Disabilities Center in Minneapolis. Students who have returned to school are followed up six months after re-entry. Periodic evaluation by established procedures has resulted in published studies by staff experts.

The Special Education projects of PACE are devoted to handicapped children and those with learning disabilities. The programs are short-term workshops; special experimental programs involving students; or other planning projects, such as a regional clearinghouse to improve special education for handicapped children through increased cooperation among rural school districts in twelve counties, funded for five and a half months in 1969.

Cooperation is maintained between schools, agencies, institutions, and other departments. Coordination of efforts among the programs is in a developmental stage. One of the programs is the Total Information for Education Systems. The goal of the program is to develop a computerized information system to serve administrative, instructional, and research functions in the seven-county metropolitan area and one non-metropolitan area.

Useful information gained through experience in the programs is disseminated through workshops, demonstrations, or other types of information exchange.

Each PACE program is evaluated. Criteria are apparent usefulness to the appropriate area of education, and acceptance by educators. Eighty-five percent of the Title III experimental programs have been continued and funded elsewhere after the experimental contract expired.

Cost/benefit calculations are not available. The programs are experimental and it may be some time before benefits become measurable.

Adequate financing is a source of concern to the various programs. Approximately 15-20% of the budget is reserved for serving retarded children. If additional funds could be obtained, additional

staff would be secured for outreach programs. Division personnel have suggested a restructuring of services by changing the Section of Special Education to a Division for Compensatory Education. Additional staff would be required. Other expansions would be in the areas of diagnosis, preschool screening, and involvement of parents.

Title IV - ESEA, Evaluation/Audit Section, Division of Planning, Department of Education

Title IV efforts are directed toward methods of evaluation of school districts. Workshops are developed to teach schools how to evaluate and audit programs. The Evaluation and Audit Section evaluates Title III experimental programs for handicapped and learning disabled children.

Title IV - Civil Rights Act of 1964, Evaluation/Audit Section, Division of Planning and Development, Department of Education

A task Force on equal opportunity works to ensure equal rights and opportunities for minority children under the Civil Rights Act of 1964. Outreach programs provide contacts with children in need of assistance. More funds are needed for additional outreach staffing.

Title V - ESEA, Planning Section, Division of Planning and Development, Department of Education

Title V funds are invested in all sections of the Department of Education. The Planning Section, in cooperation with agencies from five other states, examines acceptance of categorical grants and how they are allocated to programs for mentally retarded children. Funding is distributed for the development of education manpower according to priority of need.

3.4 Minnesota Department of Manpower Services

Special Services for the Handicapped

This program has been operating since 1954. Manpower Services has either a full- or part-time staff member assigned to each of its 33 offices as Specialist for Services to the Handicapped. This specialist also provides services to the categories of the developmentally disabled.

There are no other current projects exclusively for the handicapped, although in the past the department has a special training project for the retarded and a special training project at Red Wing that included some young people in these categories.

The full-time state supervisor of the program has functional responsibility for the full- and part-time people providing these services. Each of the full- and part-time specialists reports either to a supervisor in the Human Resources Development unit or, in the smaller offices, directly to the local office manager. The responsibilities of the specialists include the following, as described in the Employment Security Manual:

1. Securing for the applicant an equality of opportunity in employment by using successful techniques for appraising employment capacities, by insuring full and practical utilization of community facilities for vocational and physical rehabilitation, and by placing the applicant in employment suited to his capacities.
2. Obtaining cooperation of employers and labor groups in giving consideration to the handicapped worker on the basis of abilities, developing employer and union

understanding of the concepts and procedures of service to the handicapped as a part of the planned employer relations program, and giving technical assistance to employers in setting up in-plant personnel procedures that facilitate employment of the handicapped in suitable and safe jobs (see sections 7725-7764).

3. Promoting community understanding of the program of Service to the Handicapped and obtaining the community's support by presenting the program to civic organizations, social agencies, veteran's groups, service organizations, and other community groups during National Employ the Handicapped Week and in year-round educational and pro motional activities.

4. Selective placement:

   - appraisal of the individual's assets, with special emphasis on the recognition of the impairment and the evaluation of employment capacity;
   - analysis of job requirements with special emphasis on physical demands and working conditions;
   - selective matching in which the employment capacities of the handicapped applicant are matched with the requirements of the job.

5. Employment counseling when the handicapped applicant needs assistance in formulating a plan to reach a vocational goal or adjusting to a job consistent with his disability.

6. Evaluation of need for services of other agencies to improve physical and mental capacities or to otherwise enhance employability.

7. Individual job development when no job order is avail able that is consistent with the individual's employ- ment capacities.

8. Preparation of the applicant and employer for the interview to help place the factor of the handicap in proper perspective.

9. Recommendation of job modifications to meet the applicant's employment capacities.

10. Follow-up to insure that the applicant, with his disability, can perform the job safely and efficiently, and is making a satisfactory adjustment to it.

In addition, skill training can be provided through several manpower programs. Also, minor medical services are provided, through an arrangement with the Division of Vocational Rehabilitation.

Based on a special study of handicapped job applicants throughout the state in May, 1970, the three categories of cerebral palsy, epilepsy, and mental retardation accounted for approximately 5% of all handicapped applicants. The study revealed that there were approximately 275 people out of a total of over 5,500 who fit into these three disability categories in active files, and about 1,300 out of a total of over 26,000 in the inactive files. Because of recent changes in the department's information system it is impossible to know how many people in the disabilities category received services from the offices of Manpower Services during a given year. However, based on this comprehensive study for one month in 1970, we know that the percentage of all handicapped people applying for services who fit into the category of developmentally disabled is relatively small.

The new information system used throughout the Manpower Services structure collects a wealth of valuable information, including many items that would be useful in this area of developmental-

disabilities planning. However, it has been difficult to get information out of the system. First priority has been given to meeting the federal reporting requirements. For example, in the reports generated there is no breakdown on all disadvantaged applicants and services provided to them. There is no way of knowing what percentage of the disadvantaged are handicapped and, of course, no way of knowing what percentage of those who are handicapped have developmental disabilities. Representatives of the department expressed the hope that this kind of detailed information would be obtainable from their information system at some time in the future. The relationship between the local offices of Manpower Services and the local offices of other departments and agencies is informal, being maintained largely through telephone and personal contacts.

Special services to the handicapped applicants are evaluated by the state supervisor. Cost/benefit information is not available, although the necessary elements for such evaluation are in the new information system. Follow-up is routinely reported only by full-time specialists or when the applicant receives Manpower training. Measures of stability of results are made 30 days after placement on a job and six months following completion of training.

There are four full-time specialists and 34 other staff members who devote part of their time to special services to the handicapped. The total effort of these 34 people would be equivalent to about four full-time positions. They include the following job titles:

- Veterans Employment Representative; educational requirement , bachelor's degree;
- Manpower Specialist: educational requirement, bachelor's degree;

- Counselor: educational requirement, bachelor's degree plus graduate credits toward master's degree;
- Interviewer: educational requirement, bachelor's degree;
- New Careerist: educational requirement, high-school graduate.

Staff members are selected by the direct supervisor through Civil Service procedures. The numbers of staff working with handicapped applicants may change with the New Careers program, which has 20 people, eight of them handicapped, in training. Some of these may be assigned to assist in this program.

The Department is supported entirely by federal funds. The handicapped placement program is budgeted as an integral part of the total operation. Consequently, no cost information is available.

If more resources were available for this program, the department would: (a) assess the needs of handicapped applicants for planning purposes, (b) improve cross-referral to and from other agencies, and (c) provide more staff training.

3.5 Department of Corrections

This department operates several institutions for adults and juveniles. In the past, the department referred the cases of many young people that were not appropriate for correctional institutions either to the Annex for Defective Delinquents at St. Cloud Reformatory or to the Owatonna school. Since both of these institutions have been closed, these options are no longer possible. Currently, many of the retarded that come to the attention of correctional personnel are referred either to Brainerd or St. Peter. Others are returned to their home communities and may be placed in private agencies under the direction of a parole officer. Relatively few are placed at Red Wing.

As of June 30, 1970, the following numbers of persons described as being eligible for the developmental disability program were in correctional institutions:

30 boys and girls (in juvenile institutions), borderline intelligence;

8 boys and girls (in juvenile institutions), mentally defective;

32 youthful offenders, borderline intelligence;

1 youthful offender, mentally defective; 59

adults, borderline intelligence;

40 adults, mentally defective.

These numbers do not include those people transferred because placement in correctional institutions was not appropriate. No information was available on the total number of new persons who are mentally retarded or have cerebral palsy or epilepsy that comes to the attention of the correctional system each year. Although the number of developmentally disabled persons is not

large, the system does not have adequate or appropriate resources to meet their needs. Many of the welfare institutions are reluctant to accept referrals from correctional system.

Half, or more, of the juveniles in various institutions have substantial educational deficiencies. Many of these may technically meet the definitions for the developmentally disabled, and most of them require similar services.

3.6 Governor's Commission on Employment of Handicapped Persons

The Governor's Commission was created by legislation in 1965. Prior to that, the group operated for 17 years as the Governor's Advisory Committee on Employment of the Handicapped.

The objective of the Governor's Commission on Employment of Handicapped Persons is "to secure for physically, mentally, emotionally and otherwise handicapped citizens of Minnesota equal opportunity in preparing for and obtaining employment suited to their abilities and capacities in public service, private enterprise, and other fields of employment."

The commission is composed of 19 members appointed by the Governor for terms of four years each. Membership includes representatives of business and industry, labor, handicapped individuals, and the general public. Representatives of governmental and private agencies providing services to handicapped individuals serve on a variety of special committees of the commission. Members of the inter agency committee are selected by the Governor from among the heads of the state, federal, and other public agencies that have responsibilities or special interests related to the rehabilitation or employment of a handicapped person, or from among persons who are in a position to aid in rehabilitation or employment. Among the state and federal agencies represented on the commission are the Division of Vocational Rehabilitation, the State Employment Service, the Veterans Administration, Civil Service, the Department of Health, and State Services for the Blind.

One of the objectives of the Governor's Commission has been to establish area councils throughout the state. Active area

councils are operating in Minneapolis, St. Paul, St. Cloud, Duluth, Steele County, Clay County, Rochester, and Mankato. The following areas have shown interest in starting similar councils: Albert Lea, Austin, Blooming ton, Fairmont, Faribault, Hastings, Hutchison, Mankato, Marshall, Northfield, Pipestone, St. Peter, Shakopee, Waseca, Winona, and Worthington. The goal is ultimately to have 30 or more such councils operating throughout the state.

A council operates with the assistance of two full-time staff members, an executive secretary, and a full-time secretary. The commission has an annual budget, allocated by the legislature, of about $33,000.

The commission was authorized by the 1961 legislature to direct a study of rehabilitation in Minnesota. In this study, a comprehensive review of public and private agencies serving the handicapped was conducted, and a number of recommendations were made to the legislature for improvement of the total system.

The bulk of the work of the commission is done by 15 committees, whose titles and functions are as follows:

The inter-agency committee has become involved in a wide range of activities and has a number of notable accomplishments, including (a) determining a common definition of "handicapped" for inter-agency purposes among Manpower Services, DVR, the Veterans Administration, state and county government; (b) support for the ID bill allowing non-drivers to purchase ID cards
similar to drivers' licenses; (c) achieving modification of Minneapolis Civil Service procedures for diabetics and epileptics; (d) conducting a special study of Workmen's Compensation and second-injury fund applications; and (e) conducting a study (in progress) of 87 county and city governments in

Minnesota to determine the existing programs and need for programs for employment of the handicapped by local governments.

The transportation committee is working with the Metropolitan Transit Commission to improve facilities for the physically handicapped.

The mental-health, mental-retardation committee functions in an advisory capacity to the Division of Vocational-Technical Education. The committee has also raised funds to sponsor community training stations in the food industry for retarded persons.

The rural areas committee is seeking the funds to initiate a rural workshop program. It is also developing a program to train nursery workers and grounds keepers using existing rehabilitation facilities.

The architectural barriers committee has been in part responsible for new building ordinances in Minneapolis, St. Paul, and Duluth; for the provision of ramped curbing at major street intersections in these same cities; and for improved facilities for the needs of the handicapped at the State Fair Grounds. The committee also supported the passage of the new state building code by the 1971 legislature regarding accessibility to, and usability of, facilities by handicapped persons.

The legislative committee is represented on the Minnesota Committee for the Handicapped in the area of legislation.

The employers committee enlists the interests and support of various employer organizations in increasing employment opportunities for the handicapped. The committee provides articles in various association publications, and has supported recent amendments to the Workmen's Compensation and second-injury laws.

The medical committee includes industrial medical examiners concerned with the improvement of medical employment policies relating to the handicapped.

The public information committee works to publicize the successful employment of persons with handicaps and distributes announcements of awards by the Governor's Commission and the President's Committee on Employment of the Handicapped.

The women's committee sponsors the "Ability Counts" contest for eleventh and twelfth graders in Minnesota. It will also be advising to the Minneapolis Area Council on its new advocacy program, "Project Volunteer Power."

The awards committee gives recognition to outstanding individuals, employers, labor unions, and other organizations, for outstanding contributions to the employment of the handicapped.

The veterans committee enlists the interest and support of veterans and veterans' organizations and agencies, particularly for the employment of handicapped veterans in Minnesota.

The labor committee seeks the support of organized labor in furthering the aims of the commission.

The committee on home bound handicapped seeks improved rehabilitation services for home bound handicapped individuals.

The committee on community organizations ties together the efforts of existing area councils and to stimulate the development of new councils in other areas of the state.

The commission receives a legislative appropriation of about $33,000 per year. If more financial resources were available, the commission would add additional staff to provide more support to its many committees and to otherwise enable the commission to better carry out its many programs. In particular, the commission would like to provide direct assistance in setting up more area councils throughout the state.

3.7 Minnesota Advisory Board on Handicapped, Gifted, and Exceptional Children

The advisory board was established by the state legislature in 1957 as part of the Special Education Law. The board consists of 12 members appointed by the Governor, one member from each of the eight congressional districts, and four members at large. The board acts in an advisory capacity to the State Board of Education, the Commissioner of Public Welfare, the State Board of Health, and the Department of Corrections. The group usually meets about six times a year, receives no compensation, and is reimbursed for its expenses through the Department of Education.

At the regular meetings of the advisory board, representatives of the state departments of Health, Education, Welfare, and Corrections are invited to attend, as well as representatives of various organizations.

The goal of the board is to promote the development of comprehensive helping services for exceptional children across all state departments. The board holds hearings on currently important issues, sets up task forces for study of various problem areas, and makes recommendations to the Governor's Office, to individual departments, and to the Legislature.

The board develops a yearly plan of action. In the early days of the board's existence, its efforts centered heavily on implementing the special education laws that had just been passed. However, the board has always been concerned with a wider range of issues and problems. Such questions as the status of the state schools for the deaf and the blind have concerned the board throughout its history and continue to do so.

The following examples of studies initiated by the board illustrate the range and depth of its activities:

1. Several studies of the Braille School and recommendations concerning its program direction.
2. Study of state programs for the hearing impaired.
3. Statewide Governor's Conference on services for the hearing impaired, 1970.
4. Study of statewide programming for children with special learning disabilities.
5. Study of the placement of the Special Education Section in the Department of Education.
6. Development of recommendations, adopted by State Board of Education, regarding school responsibility for the trainable mentally retarded. Such service is now mandatory.
7. Study of needs in reading instruction, recommendations to legislature.
8. Study of school-excuse and school exclusion practices that led to the passage of the school-excuse law.
9. Encouragement to the Department of Welfare to do careful evaluation of programming for the mentally retarded who were displaced by the closing of Owatonna School.
10. Recommendations regarding special education rules and regulations.

If the Board had more resources, it feels it could be more effective in accomplishing its purpose. It currently must depend

almost entirely upon its membership, which serves on a non-pay basis, and on volunteers.

There are several obvious areas of overlap in function between the Advisory Board on Handicapped, Gifted, and Exceptional Children to the Advisory Council for Developmental Disabilities. The two should work closely together; in time, the two groups should somehow combine their efforts to produce effective outcomes most economically. The advisory board's assigned responsibilities cover a larger area than those of the developmental disabilities Council and include the area of the Council's concern.

3.8 Minnesota Association for Retarded Children

The Minnesota Association for Retarded Children, Inc., is the state unit of the National Association for Retarded Children. The purposes of the organization are:

1. To promote the general welfare of mentally retarded children of all ages in Minnesota and elsewhere in the home, in the communities, in institutions, and in public, private, and religious schools.
2. To research further all aspects of the problem of mental retardation -- cause and prevention, medical and social treatment, and methods of special education.
3. To develop a better understanding of mental retardation among the public and to cooperate with all public, private and religious agencies, as well as with international, federal, state, and local departments and institutions of education and health.
4. To further the training and education of personnel for work in the field of mental retardation.
5. To establish local associations of parents and friends of mentally retarded children in Minnesota; to advise, assist, guide, and coordinate the activities of these organizations; and to advise and assist parents of mentally retarded children in the solution of their problems.
6. To serve as clearing house for gathering and disseminating information regarding retarded children, and to encourage the development of integrated programs on their behalf.

7. To solicit and receive funds for the accomplishment of the above purposes.

8. To do all things and perform all acts necessary, incidental, or convenient to accomplish, carry-out, and promote the aforesaid purposes.

Eighty-one local units covering 87 Minnesota counties are affiliated with the state association. Only two counties, Cass and Clearwater, are not covered by local associations for retarded children. The state is divided into 12 regions, which typically coincide with mental-health area boundaries. The state association has part-time regional representatives assigned to each of the regions.

When individuals join local associations for the retarded, their dues automatically cover membership in the state and national associations. Early in the history of the association, members were primarily parents of the retarded, but more recently the balance is improving between parents and professionals serving the retarded.

The association has eight full-time and eleven part-time staff members. These include nine regional field representatives and two part-time secretaries.

The Board adopted 24 objectives for this year. The following are listed to illustrate the organization's highest priorities:

1. To formulate new and implement old legislation in the interests of the mentally retarded.

2. To work to implement and assist Division of Mental Retardation.

3. To improve delivery of residential services.
4. To assure existence of trainable classes by July 1, 1972.
5. To develop standards and implementation of licensure law.
6. To achieve greater involvement with poverty and minority groups.
7. To improve techniques of fund raising.
8. To develop and improve work facilities and opportunities.
9. To promote citizen advocacy.
10. To implement school-exclusion law.
11. To strengthen and support regionalization.

The total annual budget of the organization, including its operating programs, is about $700,000 a year. The breakdown is roughly as follows:

Foster Grandparent Program	$300,000 (federally funded)
Camp Friendship	$ 90,000
Other staff, administrative expenses	$330,000

Apart from the Foster Grandparent Program, which is funded entirely with federal money, the remainder of the organization's funds come from two sources, United Funds and the Friendship Campaign; the latter yields about 20% of the budget in the areas where the organization is not included in the United Fund or where no United Fund exists. Of the money received from both United Funds and the Friendship Campaign, 35% goes to the local unit, 35% to the state, 15% to the national organization, and 15% for research.

If more financial resources were available, the organization would add a full-time staff person for the Youth Association for Retarded Children. This is an affiliate group of young people divided into 30 local groups which work directly with retarded persons. The organization would also like to spend some money on the citizen advocacy program, provide more assistance to regions, provide for training of its field representatives, and add a counselor in recreation.

Although all of the organization's standing and ad hoc committees relate in one way or another to planning for the retarded, three are worthy of special note here, (a) Citizen Advocacy -- This committee is looking into ways in which the organization might develop such a program on a more formal basis for the retarded throughout the state, (b) Poverty Committee -- The relationship between poverty and retardation has been of particular concern to the organization in the last year and a half. This is one of its most active committees. It has set up ten workshops around the state to encourage agencies and professionals to work together as a group in stimulating programming in poverty areas. They have also looked into the problem of lead poisoning as a cause of brain damage, (c) Residential Facilities Committee --This committee works to form policy, provide direction to future programs, and to monitor and upgrade existing facilities.

The Minnesota Association for Retarded Children provides direct services to people through three programs:

The Foster Grandparent Program: This program, supported by federal money, has been operating under the sponsorship of the association since 1967. It gives low-income older people an opportunity to earn money and provide service. Currently, the program operates at state institutions for the retarded. Each

foster grandparent works 20 hours a week at $1.20 an hour; he or she divides his or her time between two children, in a one-to-one relationship with each of them. Currently, there are 120 older people involved in the program, 40 at Cambridge, 40 at Brainerd, and 40 at Faribault. Twice that number of retarded children participate in the program.

There is also a new foster-grandparent project funded by a two-year appropriation from the state legislature of $25,000 which provides 12 foster-grandparent positions at Fergus Falls and six such positions at Lake Owasso. The supervision of this program is provided by existing hospital staff.

Between the two programs, an estimated 276 retarded children up to age 18 are included. There are many requests to expand this program to community agencies, such as Day Activity Centers, and to private residential facilities for the retarded. There are probably several thousand retarded young persons who could benefit from this program if it were large enough to accommodate them.

It is expected that the federally supported program will continue indefinitely, while the support of the state-funded program beyond two years is uncertain.

The services provided to retarded children by the foster grandparents are quite informal. The grandparents serve as friends of the retarded children assigned to them, giving them individual attention, individual help with skill training, such as in walking, talking, and so on. Significant changes have occurred in many of the children as a result of this personal assistance.

The services are provided to a relatively small proportion of the mentally retarded young people who could benefit from this program. The program is subject to annual evaluation by federal officials. It has been well received by institutions, the retarded themselves, and others who have observed its operation and effect on the children.

The staff for this project includes one full-time director and a full-time coordinator in each of the three major institutions involved in the project.

The program is supported by approximately $300,000 annually in federal funds and $25,000 in state funds for two years. If there is more money available for this program, the association would like to see it expanded to more locations.

Camp Friendship: This is a summer camping program sponsored by the association at its camp near Annandale. It has been operating since 1965. It serves approximately 1,100 retarded persons each year. The only eligibility criteria are that the people be retarded, be eight or more years old (there is no upper limit), and ambulatory. Last year about 300 applications for the camp could not be accepted. The association estimates that if there were adequate resources, perhaps 3,000 people could benefit from this camping program.

Most of those attending are in the trainable range and are referred by families and state institutions.

There are no plans to expand or add to Camp Friendship. However, the association intends to develop more regionally based camps to meet the need. Currently, local associations sponsor two residential camps and several day-camp programs around the state.

The primary service involved in this program is recreation. Retarded persons attend for one week and engage in overnight camping, water activities, arts, crafts, and other activities. Each year a formal evaluation of the program is made; feedback from the parents is encouraged. The association notes that all of the feedback they have received has been positive.

The camp staff includes a full-time director, one full-time secretary, a half-time camp maintenance man, 55 counselors who are hired for the summer, and others who volunteer their services at the camp. The counselors are selected by the camp director and are usually recent high-school graduates and college students.

The annual budget for the camp is about $90,000. This money comes from sponsoring individuals and organizations that provide about $25,000 a year, and from charges of $59 per week for those who can pay. If more money were available for this camping program, the major change that would be made would be to develop more regional camps.

Special Olympics: This program is in its second year of sponsorship by the organization. It is designed to encourage the development of recreation for retarded persons eight or more years old. The program was started two years ago by the Anoka association for retarded children but proved too large for the group to handle. The state association then took over sponsorship. The program consists of a series of local, regional, state, national, and international athletic meets. The primary purpose of these meets is to stimulate the development of recreational programs both in schools and at the community level for retarded persons. They also provide recognition of the athletic accomplishment of many retarded persons.

There are probably 800 to 1,000 participants in the state program each year in 10 regional meets. Last year 400 people participated in the statewide meet, and the plan is to take 50 retarded persons to the national meet in Los Angeles in 1972.

The planning and operation of the Special Olympics program is done by a committee of the association with the assistance of two staff people.

Last year the program received $700 from the Kennedy Foundation. The remainder of the costs are met by the state association.

Many of the local chapters of the association start up and operate programs for retarded persons. Typically, the goal is to initiate programs; the association operates them only until they can set up their own boards and become self-directing. These programs have included a number of day activity centers, group homes, work activity programs, and sheltered workshops.

3.9 United Cerebral Palsy of Minnesota

United Cerebral Palsy of Minnesota is affiliated with the United Cerebral Palsy Association, Inc., which has its national office in New York. There are six Minnesota affiliates, in Minneapolis, St. Paul, Duluth, the Iron Range, Mower County, and Central Minnesota (the three-county area around St. Cloud). The state organization, in effect, serves the same function in the areas of the state not covered by local organizations as that served by the local organizations in their areas.

The state membership consists of the state board, which is made up of 25 people, including the officers representing the local affiliates and delegates at large from the out-state areas. These include parents of children who have cerebral palsy, physicians, teachers, businessmen, special education consultants, and other interested individuals.

The organization has one full-time associate director and a part-time secretary.

The two major purposes of the organization are to provide services to cerebral palsied children and adults, either through programs sponsored by the organization or through coordinated efforts with other agencies] and to aid in research programs for cerebral palsy.

The organization is in the process of setting objectives for the year. It is primarily concerned at this time with follow-through services, especially for adults in the Metropolitan and out-state areas. It also sees the need for additional residential facilities and work programs for both youths and adults with cerebral palsy.

A 1960 survey conducted by the organization determined that there were about 4,500 individuals with cerebral palsy in Minnesota. The organization estimates that about 60-70% of all these individuals are also mentally retarded; the remainder are of normal intellectual ability. The leading cause of cerebral palsy is premature birth. As more premature babies survive, the number of persons with cerebral palsy also increases.

The total annual budget of the organization is approximately $64,500. The major sources of funds are the local affiliates, other organizations and foundations in the state, and direct solicitations in out-state areas not covered by local affiliates.

The long-range goal is to use some of this money to match state or federal funds and expand the organization's activities. If more money were available to the organization, it would increase its activities in two areas: (a) it would set up additional service committees or county committees to initiate programs in local areas and to stimulate existing programs in various regions of the state; and (b) it would develop or stimulate additional services for adults with cerebral palsy -- such as home bound programs, particularly for rural people, and possibly mobile therapy units.

The organization has a professional advisory committee made up of professional people on the board, ex-board members, physicians, special education people, psychologists, nurses and others. The major function of this advisory committee is to help identify immediate needs.

The organization has one operating program that has been functioning since 1966, a clinic operating at Fairview Hospital in Minneapolis, and at a satellite station in Virginia, Minnesota.

The Fairview diagnostic clinic serves persons suspected to have cerebral palsy; they are usually referred by physicians, parents, social workers, or nurses. It is estimated that this year the Fairview unit will provide 72 evaluations and approximately 50 follow-up visits for people seen at the clinic earlier. The average age of children seen last year was 7 1/2 years old. Half of those evaluated were considered to have moderate to severe cerbral palsy and half had minimal afflictions.

The Virginia unit accepts approximately 36 people for service each year, plus others who return for follow-up visits. There is approximately a three- to four-month waiting list for service at this clinic.

Diagnostic and evaluative service is provided during a two-day period, during which a person with cerebral palsy or suspected to have cerebral palsy is seen by a team of as many as 12 professionals, including a neurologists, orthopedist, pediatrician, dentist, social worker, physical therapist, and an ophthalmologist. The team then meets with the parents to discuss its recommendations for education, day care, treatment, or whatever. Follow-up visits are usually scheduled to be made six months following the evaluation.

This diagnostic service was originally funded by the Department of Public Welfare under its unit for services to crippled children. That unit withdrew its support some time ago and has not renewed it since then. The association hopes to find state funds for the continuing support of the service.

Five of the six affiliates in the state have operating programs. In Minneapolis, United Cerebral Palsy operates a sheltered

workshop and a day activity center, primarily for persons with cerebral palsy but also for some others. They also operate a work-activity program in conjunction with the day activity center. The Duluth branch operates a day activity center and recreation program, and Iron Range and Mower County (Austin) units also operate day activity centers.

3.10 Minnesota Epilepsy League

The Minnesota Epilepsy League is incorporated as a nonprofit organization in the state of Minnesota. It has been operating since 1957. Its broad goal is to help epileptics in Minnesota to become well-rounded citizens through programs of education, referral for services, and advocacy.

There is a National Epilepsy League, but the state organization is not formally affiliated with the national group, primarily because it would drain the organization's limited financial resources.

There are five local chapters, in Duluth, Minneapolis, St. Paul, Tri-County (St. Cloud), and Mankato-St. Peter.

Members of the organization include epileptics themselves, parents of epileptics, teachers, and other professionals. A firm membership figure is not available, but the organization maintains a mailing list of about 5,000 people.

The organization has a lay board made up of officers and others who determine policy and ensure implementation. There is also a medical advisory board, which formally meets once a year. This board is made up of the medical members of the organization, who report on new research in the area of epilepsy and help with the organization's educational programs.

The organization operates with an annual budget of about $10,000. This is made up of money from Minneapolis and St. Paul United Funds, United Funds from several other cities in the state, contributions, and membership dues. If more resources were available to the organization, its members would like to add

staff to assist in starting local chapters, provide more educational programs, and do additional advocacy services.

The organization has a variety of committees, including an ad hoc committee on developmental disabilities legislation. The only staff consists of a two-thirds-time executive secretary.

The specific objectives of the organization are (a) to educate the epileptic himself in terms of the nature of the disorder; (b) to educate the general public about the nature of epilepsy; and (c) to provide a referral and advocacy service for epileptics.

The specific short-range priorities of the organization, established by the board, are to broaden its educational program, particularly in the schools (for example, the organization hopes to be able to influence the curricula in health classes throughout the state); and to provide both educational and advocacy services to larger numbers of epileptics.

3.11 Minnesota Rehabilitation Association

This group is the Minnesota branch of the National Rehabilitation Association. Its objective is to make Minnesota a better place for the handicapped to work and live. Its members include the range of professionals working in various aspects of rehabilitation who are employed in public and private agencies or in business and industry, as well as concerned citizens and the handicapped themselves.

Its governing board is made up of the officers, nine regional representatives from across the state, and representatives of two organizational affiliates within Minnesota — the Rehabilitation Counseling Association of Minnesota, and the Vocational Evaluation and Work Adjustment Association. The board determines policies, objectives, and priorities for the organization. The organization has no paid staff members. Planning is done by the board and relates to planning in other organizations and agencies only in that its members include people involved in planning in these other settings.

The annual budget of the organization is approximately $2,500. This year it is attempting, through its "booster club," to raise an additional $4,000 or more. This money is used to publish a monthly newsletter, pay committee expenses, develop affiliate organizations, run membership drives, and meet program expenses (mailings, etc.). If additional money were available to the organization, it would consider hiring a part-time executive director, whose function would include legislative activity in the interests of the association.

MRA's primary objectives for the current year are included in the functions of an existing legislative committee, plus four newly created committees:

1. The legislative committee intends to develop a legislative plan covering both state and national legislation. This committee works closely with the Minnesota Committee for the Handicapped regarding state legislation and will try to produce a direct impact on federal legislative plans.

2. A new committee on sports and recreation for the handicapped plans to encourage the development of expanded recreational opportunities for the handicapped throughout the state.

3. The architectural barriers committee plans to continue working closely with the Governor's Commission on Employment of Handicapped Persons in bringing attention across the state to the needs of handicapped persons in regard to architectural barriers and to publicize what is being done.

4. The public information committee plans to get information to the general public throughout the state about the accomplishments of rehabilitation.

MRA, as such, does not provide direct services to handicapped people, but its members represent both public and private agencies that do provide such services. It does provide consultation and financial assistance to newly forming professional affiliate groups.

3.12 Minnesota Association of Rehabilitation Facilities

The Minnesota Association of Rehabilitation Facilities is a chapter of the International Association of Rehabilitation Facilities, Inc. Its stated purpose is "to stimulate interest and assist in providing suitable programs of rehabilitation and employment for handicapped individuals" by:

- developing and establishing minimum standards for member agencies;
- providing for consultation and exchange of ideas and experiences among member agencies through professional, public, and legislative education;
- providing a basis for unity and common action through professional, public, and legislative education by member agencies;
- cooperating in the development of broader programs of rehabilitation through coordination of efforts with other agencies in the community offering such services.

The members include 32 rehabilitation facilities throughout the state and several individual associate members who are interested in the work of the association. Several of these are from public agencies. The member facilities include vocational rehabilitation centers, medical rehabilitation facilities, and sheltered workshops. In the future the membership may expand to include day activity centers and state institutions with rehabilitation programs.

The board, or executive committee, consists of the officers and four regional representatives, one each from the northern half

of the state, the southern half, the eastern metropolitan area, and the western metropolitan area. The executive committee sets policy for the organization. There is no paid staff.

The organization has a newly constituted long-range planning committee headed by the president-elect. The only specific objective that would have relevance here is the organization's goal to obtain a voice in planning the developmental disabilities program for Minnesota.

The organization's funds come from dues charged to members and money returned to the state organization by the international association. Its annual budget is quite small and covers mailings and program expenses. If the organization had more financial resources it would like to hire a full-time executive director.

The association's legislative committee works with the legislative committee of the Minnesota Rehabilitation Association and the Minnesota Committee for the Handicapped to provide informational input in the development of both state and federal legislation in the area of services to the handicapped.

The association itself provides no direct services to the developmentally disabled or other handicapped individuals. However, the member agencies provide a wide range and high volume of diagnostic, treatment, information and referral, and advocacy services. Private agencies in the communities are frequently called upon to provide information and referral services to a wide range of handicapped individuals. Private agencies are in a particularly good position to provide this service, in that they relate to all of the public agencies as part of their daily work.

The organization does not have a planning relationship with other agencies and organizations serving the handicapped. However, its members feel strongly that the association should have a stronger role in such planning. The private facilities tend to become involved in planning only after allocations are made and program needs are determined by the governmental agencies. Members of the association feel that private facilities should have an earlier, stronger role in planning because, in fact, they provide a very large portion of the total services received by handicapped people in the state.

The association does not develop or collect information on the numbers or needs of developmentally disabled or other handicapped individuals in the state. Member agencies, of course, do collect information on the people served by these agencies -- their characteristics, services provided, results achieved, referrals made to other agencies, and so on.

One of the basic problems in using the information collected by agencies is that it is typically developed for the immediate program needs of the agency itself. Consequently, the information is not compatible between departments and does not necessarily reflect the needs of the citizens of the state.

3.13 Minnesota Administrators of Special Education

The membership of this organization, which was formed four years ago, is made up of 70 administrators or supervisors of special education programs. The purposes of the organization are (a) "to provide opportunities for discussion of problems common to its members with a view to the development of improved services for exceptional children in the state of Minnesota"; and (b) "to support the aims of the Minnesota State Federation of the Council for Exceptional Children."

The organization also serves as a vehicle for two-way communication with the State Department of Special Education, and it enables administrators of Special Education throughout the state to have a unified voice with which to speak to the state Legislature.

Approximately 80% of the state school districts that have special education programs are represented in the organization's membership. . The organization also has associate members -- some state department officials and others interested in special education.

The organization operates on an annual budget of about $300, which primarily covers mailing and program expenses.

As part of the organization's educational program for its members, it is planning a spring workshop; the first one sponsored by this group will be held in 1972. The primary topic for that workshop is likely to be the implementation of the Mandatory Trainable Act.

The primary problem in the provision of services to the developmentally disabled indicated by the organization is the need for more preschool education and other early intervention.

Further information on Special Education is provided in the description of the Special Education Section of the Department of Education.

3.14 Minnesota Association of Mental Health and Mental Retardation Programs

This association is made up of representatives of all 26 mental-health centers throughout the state; it includes directors, staff members, and board members. The organization operates without any staff of its own and uses as funds a $25 assessment from each of the member centers. It conducts spring and fall workshops for its members.

The location of the mental-health centers and descriptions of their functions can be found in the section of this report that describes the Department of Public Welfare. While the centers' programs differ considerably around the state, by 1972 each will be served by advisory boards for mental health, mental retardation, and inebriety.

The association meets regularly with representatives of the Minnesota Mental Health Association, the Minnesota Association for Retarded Children, the Association for Alcoholism, and the Department of Public Welfare.

3.15 Mental Health Association of Minnesota

The Mental Health Association describes itself as a voluntary health agency that serves as advocate for the mentally ill and emotionally disturbed in Minnesota. "Our function is . . .to see that adequate mental health services are provided, to serve as citizen representatives in monitoring existing mental health services and planning new delivery systems, and to help safeguard the rights and interests of persons utilizing mental health services."

The association has 19 chapters throughout the state that represent areas served by one or more of the 25 community mental health centers. Five additional chapters are being either formed or reorganized. The membership, about 3,000, is made up of concerned citizens and mental-health professionals. The association has 12 1/2 paid staff members including 4 1/2 field representatives, who assist in the development and support of local chapters.

Two of the association's goals for 1972 are relevant to planning for the developmentally disabled:

1. To advocate a comprehensive program for the state aimed at the prevention, identification, and treatments of "childhood mental illness."
2. To participate actively in the development of a plan for coordinating various state and local mental-health services, and the possible reshaping of the state's role in the delivery of services.

The annual budget of the association is approximately $180,000, which comes from United Funds, dues, and contributions. If

additional money were available, the association would add staff, including a program specialist in the area of childhood mental illness.

The members of the association and its Children's Committee feel strongly that the lack of mental-health services is the greatest gap in the mental-health-care delivery system. They are trying to draw attention to this need, which they see as inadequately recognized even by human-service professionals. Although figures are not available to document the extent of this need for children, the association says that a great many children need diagnostic services for emotional problems, residential services, and equal opportunity for education.

Chapter 4. INFORMATION, REFERRAL, AND ADVOCACY SERVICES

Each of the agencies and organizations surveyed was asked about the educational, referral, and advocacy services it provides to the developmentally disabled. The range of services provided in these areas varies considerably.

4.1 Information and Referral Services

Most of the agencies and organizations contacted provided some sort of information and referral services for the people they serve. None operates or participates in sponsorship of the type of public information and referral centers of services that could be used by a wider segment of the population. They do not have structures that help them locate new clients and refer them to appropriate public and private services. (One such community-based information and referral center is being developed in Duluth as part of the Model City program there.)

Department of Public Welfare

Welfare provides information and referral services to a greater or lesser extent through most of the programs that are described in Chapter 3 of this report.

Department of Health

There is no separately structured information and referral service, but all requests for information are taken care of. District nurses, as well as other official Health Department staff, provide information about appropriate resources to people they serve. In addition, a large variety of educational materials related to specific health problems is available.

Department of Manpower Services

The department's Specialists for Services to the Handicapped provide information and referral services to applicants. Specific forms are used for referrals to and from the Division of Vocational Rehabilitation and State Services for the Blind, and also for obtaining medical, psychiatric, and other information from a variety of sources. In these instances, provision is made for feedback on the acceptance of the referral and results of services provided. Referrals of most other kinds are made more informally, although follow-up by direct contact with the agency is supposed to occur following every referral. No information is available on the percent of referrals accepted. Some of the local offices have community-resource handbooks for use in making referrals; these vary in adequacy. Referrals are most often made to the Division of Vocational Rehabilitation, State Services for the Blind, Welfare, Veterans Administration, and various health programs. There is no information on the numbers of referrals.

Division of Vocational Rehabilitation

Division of Vocational Rehabilitation counselors throughout the state refer their clients to other agencies for needed services not available in Division of Vocational Rehabilitation on an ongoing basis. The referral format used depends on the requirements of the agency to which the client is being referred. Referrals are made both by phone and by mail. Based on overall experience, it is estimated that 50% of their referrals are accepted for services. There is usually some follow-up, although it follows no standard procedure. Most frequent referrals are for medical evaluation or services, education, skill training, and vocational evaluation.

Special Education

Information and referral services are provided in individual schools, typically by the social-work staff or through the principal's office on recommendation of the teacher. There really is no good system for making or following up such referrals. The state office has no information on the volume of such referrals.

Department of Corrections

Information and referral services are provided at several points in the continuum of the criminal justice system --by police, county attorneys, judges, probation officers, reception and diagnostic centers, institutions, and parole officers. The nature and adequacy of referrals made vary considerably and depend on the resources of the people involved. There is probably too much dependence on the Reception and Diagnostic Center at Lino Lakes to determine needs and make referrals. The whole process of matching people to needed resources should be simplified as more regionally based assessment and treatment resources are developed.

Governor's Commission on Employment of Handicapped Persons The commission office gets as many as fifty calls per week from handicapped individuals or their families who are either having problem locating appropriate services or in obtaining the service they need. Referrals are made to individuals within appropriate agencies and specific appointments set. Both the client and the agency are encouraged to call back regarding the outcome of the referral. No information is available on the percent of referrals accepted for services, although it varies between agencies. The commission office finds that existing community resource handbooks are of limited usefulness.

Minnesota Epilepsy League

Two of the primary functions of the organization are making referrals and providing information about epilepsy. Information about epilepsy in general is provided through mailings of material to interested persons, membership programs, and presentation to various professional and school groups. The organization's part-time executive secretary is the only staff person providing these services.

Referrals are most often made to physicians, the Division of Vocational Rehabilitation, Manpower Services, family service agencies, and welfare departments. Referrals, typically handled by phone, are always made to specific individuals within agencies. People are encouraged to call back if they have difficulty getting the help they need. No information is available on the volume or results of these referrals.

Minnesota Association of Rehabilitation Facilities The association itself provides no information and referral service, but the member facilities serve this function, in local communities both for the clients they directly serve and for others seeking information on where to obtain various services.

Mental Health Association of Minnesota

This association has one full-time staff member who provides information and referral services. Requests for information on mental health and mental-health services are usually met with printed materials. Many people call or write asking where to go for help; these are most often referred to the community mental-health center in the interested party's area. Follow-up on these referrals is done in certain cases; information is not available on the volume of such referrals. The major difficulties cited in providing this service are the difficulty in determining what

services are actually provided by various agencies, and the difficulty in maintaining current information on new and changing programs.

4.2 Advocacy

Most of the agencies and groups contacted indicated that they were directly involved in some form of advocacy for developmentally disabled or otherwise handicapped persons. Few had identifiable advocacy programs or staff. Most felt that, in spite of the variety of current advocacy efforts, there are still many unmet needs in this area.

The most frequently mentioned need was for one-to-one advocacy for individual handicapped persons to ensure that needed services are provided. Such a resource would be concerned about the appropriate provision of services in both public and private agencies. Also suggested were some combination of advocates in both the public and private sectors.

Several organizations were listed as being particularly effective in serving as advocates, either to individuals or to groups. The Association for Retarded Children was felt by most to be effective because of strong leadership and the involvement of many concerned parents. Alcoholics Anonymous and organizations for the blind and for the deaf were said to be particularly effective because they focus on self-help.

Department of Public Welfare

This department provides guardianship services, review boards, humane practices committees, and individual employees who feel a sense of responsibility for the retarded.

Department of Health

Advocacy efforts of the Department of Health are limited to outreach efforts for their immunization and venereal disease programs and in helping communities develop resources, such as family planning clinics, to meet health needs.

State Planning Agency - Comprehensive Health Planning The prime functions of the Comprehensive Health Planning effort are to bring health and health-services issues to public attention and to invite interaction among planning bodies, providers of services, and consumers, toward the goal of improving services. This is, in effect, an advocacy function for all people in the state who ever need health care.

Division of Vocational Rehabilitation

The Division of Vocational Rehabilitation does not have a separate structure for dealing with advocacy on either the state or regional levels. The nature of their work, however, guarantees advocacy on several levels, since they are primarily concerned with direct counseling and referral service.

DVR does encourage use of community resources and in the course of daily activities makes direct referrals. As part of the establishment of eligibility, persons are informed of their legal rights to obtain services. Advocacy is provided for groups and for individuals according to the needs and the counselor's assessment of community resources to meet these needs.
There is considerable work with agencies and individuals to ensure that the DVR clients receive optimal service.

Special Education Section

The state office resolves differences between parents and local school districts regarding the provision of special education services to children. While most of these differences are resolved by Special Education regional staff people, the staff directly handles 40 to 60 such cases each year. The St. Paul School District is the only one in the state that has a person specifically assigned to deal with parents, parent groups, and other agencies regarding handicapped children in the schools.

The Department of Education, in cooperation with the Department of Corrections, is just starting two pilot youth-advocacy projects in Minneapolis and Duluth. In these projects, full-time advocates will work with groups of young people returning to regular schools from various correctional programs.

The Director of Special Education noted that it is possible for special advocacy projects to be funded under Title VI, although no Minnesota districts have yet applied for funds to conduct such projects.

Vocational-Technical Division, Department of Education This division does not have a formal advocacy program in the state office. They do receive about 75 requests per year from individuals who need help, and they attempt to act as a referral agent. Most of the requests come from persons not eligible for assistance from the Division of Vocational Rehabilitation. Within the funded programs there are at least sixty counselors who act in an advocacy role as part of their duties. Members of the Division advocate programs through speaking engagements in various communities. A considerable amount of time is spent with industry in attempting to encourage the hiring of handicapped

persons. The weakest part of this advocacy program results from the difficulty in finding instructors who understand industrial needs.

Department of Education, Title I

There is no formal advocacy role within the Title I program at the state level. Members of the staff receive about 50 phone calls a year from individuals who request information about availability of remedial programs, or complain that given schools are not providing adequate help. When these calls are received they are logged in an informal manner. Referral information is given as appropriate. Complaints are handled by direct phone contact with schools. No follow-up is made, but the staff impression is that there are few, if any, repeat calls of complaint, so it may be assumed that schools respond concerned individuals.

The division is involved in encouraging persons to use existing community resources, informing persons of their legal rights to obtain educational services, and working with schools to ensure that programs are provided to persons with the most severe learning handicaps — regardless of the cause of the educational difficulties.

The division has been quite active in encouraging parent advisory committees to work with school administrations and provide an advocacy channel in this way. This is potentially the strongest advocacy program sponsored. The weakest aspect of this is the difficulty in locating parents who will take an active part in such programs.

Department of Manpower Services

The department, through its state office and handicapped-placement specialists in local offices, provides a number of advocacy functions:

1. National Employ the Handicapped Week activities in Minnesota are the promotional responsibilities of Manpower Services. The local offices coordinate the activities at the local level.

2. Several representatives of the department serve on committees of the Governor's Commission on Employment of Handicapped Persons and many of the people from local offices are active in local area councils for employment of handicapped persons.

3. A new experimental project, "Project Volunteer Power," being conducted in three cities under sponsorship of the federal Department of Health, Education, and Welfare, will be starting in the Minneapolis area soon.. The project is being sponsored by the Minneapolis Area Council on Employment of the Handicapped. Manpower Services staff have been involved in the planning. Under Project Volunteer Power, women will be advocates for handicapped individuals.

4. The major advocacy services of the specialists in job development is encouraging employers to hire individual handicapped persons.

5. The specialists also encourage applicants to use existing community resources, provide information about kinds of services available, refer people to a variety of community resources, and follow up to determine if services have been provided.

Although it is difficult to assess the effectiveness of these various advocacy efforts, those representatives interviewed from the department feel that they have had some impact in changing the acceptance of handicapped applicants by employers. The level of acceptance varies directly with the state of the economy and the availability of jobs. As jobs become less available, naturally placement of handicapped persons becomes much more difficult.

One of the most significant advocacy needs indicated by department representatives is increasing employer acceptance of handicapped persons with non-visible handicaps, particularly those of the epileptic. They indicated that the most effective way of getting employers to hire the handicapped is to use the experience and recommendations of other employers.

Department of Corrections

The Departments of Corrections and Education are cooperating in a new project providing advocates to work with young people returning to regular schools from correctional institutions. Eighteen such advocates will be working within schools in Minneapolis and Duluth.

Corrections Department representatives indicated that developmentally disabled persons who come to the attention of the criminal justice system need some sort of advocate to help them receive appropriate services and to assure that they are placed in the appropriate institution, either within or outside the Corrections Department. Advocates are also needed to help developmentally disabled persons return to their communities.

It was suggested that the need for advocates may diminish as more community services are available and as more human service workers develop an "advocacy attitude" toward the people they serve.

Governor's Commission on Employment of Handicapped Persons The Commission as a whole is serving a broad advocacy function for the handicapped, particularly in the area of employment. The Commission office, and the Executive Secretary in particular, provide an individual advocacy service to many people. Currently, they have a file of 150 people for whom the Commission office is, in effect, acting as advocate. The Commission is called upon both by people needing help in obtaining services from appropriate agencies and from employers who are asking for qualified handicapped applicants.

The most effective aspects of the Commission's advocacy efforts have been:

- passage of the Second Injury Law,
- modification in laws affecting architectural barriers,
- distribution of access symbols for use in buildings that can accommodate handicapped persons, and
- modification of building codes in several cities.

The least effective advocacy efforts of the Commission have been in the area of individual advocacy; the office has only limited resources to provide adequate follow-up to individual handicapped persons. The Commission feels strongly that, based on its own experience, more individual advocacy services are needed to help people locate appropriate services, and to ensure that needed services are provided.

Minnesota Advisory Board on Handicapped, Gifted, and Exceptional Children

Occasionally, members of the board are asked to become advocates of individuals who are having difficulty locating appropriate services or making appropriate arrangements with individuals in other departments. In its official capacity, the board serves

as an advocate for the broad groups of children throughout the state. It has been the experience of the Advisory Board that class advocacy — advocacy for various groups of people — is greatly needed, particularly to produce changes in service-delivery systems.

Minnesota Association for Retarded Children

The association is involved in advocacy in several forms, both for retarded persons, in general, and for specific individuals. Some examples of the organization's advocacy efforts follow:

1. The organization helped in formulating the guidelines and was involved with the implementation of the cost-of-care legislation.
2. The Division of Retardation in the Department of Public Welfare was promoted by the association.
3. Day activity centers in Minnesota were initiated by the association.
4. The association, by gathering strong grassroots support, helped in the passage of the Mandatory Trainable bill. State and local associations will be working with school districts to help them provide services to the trainable retarded.
5. The association works to improve the care provided in state institutions for the retarded.
6. The association acts as an advocate for individuals who are either not getting any service or are getting inadequate service.

The feels that it has been most effective in getting legislation passed and in assisting implementation. It feels that it has not been effective enough in educating physicians to inform parents about and refer them to the association. It also feels it needs to improve its outreach in finding parents and encouraging parent-to-parent counseling.

The most significant needs for advocacy are in one-to-one relationships, particularly for individuals who are moving back into a community from one of the institutions.

Several advocacy programs were cited as particularly effective. The Nebraska Association for Retarded Children has had considerable success in assisting the state to develop a network of community-based services and specific advocacy programs. The Ohio Association for Retarded Children is using Developmental Disabilities money to develop and conduct an advocacy service in that state.

United Cerebral Palsy

This organization has no formal advocacy program, but its members often serve as advocates for individuals who need assistance. The organization is also involved in several group-advocacy activities. The organization sponsors and actively works with the Minnesota Committee for the Handicapped regarding legislation; periodically sends material on cerebral palsy to county welfare departments, public health nurses and school nurses; and prepares articles about cerebral palsy, individuals who have cerebral palsy, and the activities of the organization for papers throughout the state.

Minnesota Epilepsy League

Advocacy for individuals and for epileptics as a group is one of the primary functions of this organization. The league was instrumental in reducing the number of years epileptics must be free

of seizures before they may qualify for drivers' licenses from two years to one year. The organization also arranged for an insurance company to insure epileptics for life insurance and hospitalization under a group policy.

The problem with which epileptics need the most advocacy assistance is employment. Epileptics have great difficulty getting and retaining jobs. The unemployment rate of epileptics has been estimated at 25%. The organization concentrates its advocacy efforts on schools and industry, trying to change attitudes and restrictive practices. The director and many of the board members make frequent presentations to schools and professional groups for this purpose.

Minnesota Rehabilitation Association

This organization serves as an advocate for all handicapped persons in the state. It is a sponsor of and works closely with the Minnesota Committee for the Handicapped in its legislative efforts. Through its membership, newsletters, and programs, the organization calls attention to the needs of handicapped people. The president of the group indicated that each handicapped individual needs one source or professional individual to see that the full range of needed services is provided in the most appropriate fashion.

Minnesota Association of Rehabilitation Facilities Although this association provides no advocacy services as a group, its member facilities frequently serve as advocates for individuals who need help locating or obtaining needed services.

Mental Health Association of Minnesota

The major function of this association is advocacy. Many of the local chapters operate "One-to-One" programs with volunteers

helping and serving as advocates for patients in institutions and patients who are returning to their communities.

The group-advocacy of the state association covers a range of activities:

1. Association staff serve on the Humane Practice Committee for state institutions and on other task forces, committees, and boards for community and regional planning.
2. The association supports legislative changes in such areas as cost of care for mental-health services and patients' rights to treatment.
3. The Forensic Committee, made up of attorneys and mental-health professionals, reviews the commitment process and recommends needed changes.
4. The association directs community education and training, particularly for groups that care for persons who are in trouble.

Additional advocacy efforts are needed to reduce employers' discrimination against people with histories of mental illness and to obtain the right to treatment for hospitalized patients.

Chapter 5. INTERACTION AMONG AGENCIES AND ORGANIZATIONS

The interaction among the public agencies, organizations, and other groups interviewed varies considerably. Some of these groups make a deliberate effort to get broad involvement on their various committees for planning purposes; but others depend on informal contacts or have no connection whatsoever with other groups — even though they may be concerned about or work directly with many of the same people. Even where there is some formal interaction, its effectiveness is usually limited. Most of the interaction described in this chapter is more in the nature of information-sharing than joint planning. There was little readily available evidence that such interaction has led to concrete changes in program direction. All of the groups expressed their hope that the Advisory Council on Developmental Disabilities might serve as the much needed mechanism for productive interaction.

On the following page, Table 4 contains the level of interaction between each of the major governmental departments and all other agencies and organizations covered in this survey. Not shown is the minimal interaction among many of the private groups, even though they share many of the same concerns and problems. The major exception to this is legislation, concerning which there has been considerable interaction and cooperation in the last few years, particularly since the formation of the Minnesota Committee for the Handicapped.

Table 4; AGENCY INTERACTION CHART

CODING KEY

0 - No relation
1 - Formal
2 - Informal
3 - Formal and Informal

	CATEGORIES						
	Education (Vocational Education, Special Education)	Welfare	State Planning Agencies (Comprehensive Health Planning)	Minnesota Health Department	Advisory Board on Handicapped, Gifted and Exceptional Children	Manpower Services	Department of Vocational Rehabilitation
State Department of Correction	3	3	3	0	1	1	3
State Department of Education	-	1	3	2	1	1	3
Minnesota Department of Health	2	1	3	-	1	0	3
Minnesota Department of Manpower Services	3	1	1	0	0	-	3
Minnesota Department of Public Welfare	3	-	3	3	1	1	3
Governor's Commission on Employment of the Handicapped	3	1	0	0	0	2	1
Minnesota Rehabilitation Association	3	2	0	0	0	2	1
Minnesota Association for Retarded Children	3	3	3	2	2	2	2
Minnesota Epilepsy League	0	1	0	2	0	2	2
United Cerebral Palsy of Minnesota	3	1	0	0	0	0	2

Minnesota State Medical Association	3	1	3	1	0	0	2
Minnesota Association of Rehabilitation Facilities	0	0	0	0	0	0	1
Governor's Advisory Board on Handicapped, Gifted, and Exceptional Children	3	1	3	1	-	0	1
Minnesota Association for Children with Learning Disabilities	0	0	0	0	2	0	2
Minnesota Association of Mental Health Programs	3	1	3	0	0	0	0
Minnesota State Planning Agency	3	1	-	1	2	2	2

Chapter 6. PLANNING AND THE USE OF INFORMATION

The survey of agencies and organizations was designed to determine how planning is done, what current efforts at joint planning might be, and what regional planning and kinds of information are being used for planning purposes.

6.1 Planning

The purpose and process of planning are perceived differently by various departments and organizations. There is little uniformity in the areas covered in plans, staff involvement, specification of objectives, and the use of data in the process.

Most planning appears to be reactive -- that is, it is stimulated by specific requests, or demands from state or federal agencies. Federal or state legislation and regulation often prescribe the content of planning. No group of agencies appears to be starting with the total needs of people, then determining how and where to meet them. Organizations whose planning most closely follows this sequence are the Association for Retarded Children, United Cerebral Palsy, and the Epilepsy League, who are concerned about' all the needs of all persons who are retarded, epileptic, or have cerebral palsy. Consequently, they help reveal the ways in which various agencies and departments divide, share, duplicate, or overlook parts of the needs and problems of other persons.

Some groups indicated that their knowledge of and resources for planning are limited. Many times they have been asked to plan but have not had the resources to do it well.

Cost/benefit information is almost totally lacking because of inadequate measures of both costs and benefits. Cost calculations vary considerably between, and even within, departments; and benefit measures, where they do exist, are crude. Little attention is given to the stability of results achieved or to the many people who fail to complete programs. All this makes it difficult to identify effective programs, parts of programs, or those whose costs are out of line in relation to benefits.

Joint Planning

There is much sharing of plans among agencies, departments, and organizations; and there is some evidence of cross-participation in the planning process. Committees and task forces are the means used; however, the incentives for such planning are weak and often not even present. Influence from the private sector has resulted in some program change in state-agency operation.

Local and Regional Planning

There is no general agreement that there should be more planning at the local and regional levels. Currently there is little incentive for local planning. Local or regional groups have had little or no control over available funds or public resources in their areas.

The service-providing organizations all have some sort of regional structure, even though their boundaries are dissimilar. The private groups are all working toward more local involvement, which would provide input to both local and regional planning. (For information on state office regional boundaries see Chapter 2.)

6.2 Information Used for Planning

Most agencies and organizations use estimates of incidence of disability. Systematic surveys assessing actual needs have been done only in a few, small areas of the state. Estimates of incidence do not necessarily lead to accurate estimates of how many people need particular services. Some agencies focus their attention more on the number of people eligible for particular services than on the total number who might need assistance.

Few programs systematically collect information on the relevant characteristics of the people they serve, the services provided, the costs of these services, or the results achieved. When some of this information is collected, there is usually no way to tabulate it. Some state departments collect little information on the activities of their local units. Different coding systems and definitions make comparison among programs impossible. There is no central pool of information. There is no way of determining how many people are being served by more than one agency, and absolutely no way of getting unduplicated tallies of people served. Currently, there is no accurate way to identify people not being served -- either by name or by estimation. Because each agency focuses on the problems of people for which it provides services, there is no systematic identification of the unmet service needs of these people. People tend to receive the pattern of services offered by the first major agency they encounter. For example, if an agency is medically oriented, its clients' vocational needs may not be identified.

Potential Sources of Information on Needs

Several statistics could be used for estimating incidence of developmental disabilities in Minnesota, but there is no uniformly accepted system. A California Study Commission on Mental Retardation

estimated that 1.83% of the population of California is developmentally disabled. The state of Wisconsin adapted this figure to the Wisconsin population and estimated that 1.857% are developmentally disabled. (This procedure is described more fully in Appendix G of the report, Developmental Disability Plans - A Five-State Survey.)

The Ohio plan for Developmental Disabilities estimates that 1.7% of the population is mentally retarded, 2% epileptic, and .14% afflicted with cerebral palsy. Members of the Minnesota Epilepsy League feel that the commonly used estimate of 2% epileptic is conservative. Some authorities estimate that 7-13% of epileptics are also mentally retarded. United Cerebral Palsy of Minnesota estimated in 1960 that there were about 4,500 individuals with cerebral palsy in Minnesota. They also estimate that approximately 60-70% of these are also mentally retarded.

In a 1968 study prepared for the Minnesota Comprehensive Health Planning Agency by Stanford Research Institute, Planning Study for Residential Care in Minnesota, prevalence of mental retardation was estimated at between 1% and 1.5% of the population. They estimated that roughly 1,000 children born each year in Minnesota would require special attention because of retardation.

Estimates such as the commonly used 3% morbidity figure for mental retardation can be misleading; this estimate includes the group with borderline ability who are not substantially disabled. Such gross estimates are not necessarily useful for determining service needs. Prevalence rates for such various subgroups as "profoundly retarded" or "cerebral palsied with mental retardation" are somewhat more useful because the service needs are more homogeneous.

Several programs have estimated the numbers of developmentally disabled persons who are not currently served but who could benefit

from service. The Division of Vocational Rehabilitation estimates that there are about 4,000 developmentally disabled persons who could benefit from DVR services. The Special Education Section estimates that 22,000 developmentally disabled children need special education services but will not receive them this year. This includes 2,100 trainable mentally retarded, 7,600 educable mentally retarded, and 12,300 children who have learning disabilities.

In other areas of services, the Minnesota Association for Retarded Children estimates that several thousand retarded persons could benefit from the Foster Grandparent Program, particularly if it were expanded beyond the institutions, and that 3,000 retarded persons could benefit from summer camping programs, such as provided at Camp Friendship.

The Mental Retardation Facilities Plan of 1969, prepared by the Department of Public Welfare, described the needs for services and facilities for the retarded. The needs of each county and region (using six regions for the state) are ranked according to five factors, (1) the percent of mentally retarded being served, (2) the percent of low-income families, (3) the per-capita income, (4) the median adult education, and (5) infant mortality rates. The estimates of unserved retarded were determined by comparing numbers of people served by existing facilities with estimates of potential need. For example, the plan estimates that diagnostic and evaluation services are needed by 400 persons per million population, and sheltered workshops by 0.1% of the population over age 19.

6.3 Identifying Developmentally Disabled Individuals

There are several existing means by which developmentally disabled individuals who need special attention could be identified.

Suggestions have been made for several years that some sort of central, statewide registry of people who need and who receive services be developed. It may be that efforts at combining or centralizing such information should be concentrated at the local or regional levels. This would be a significant aid to planning, outreach efforts, and local or regional coordination of services.

No one source is comprehensive and there is considerable overlap, but methods could be developed for combining the information from these sources and removing duplicates. Such a registry could mean that more developmentally disabled people would be identified and served. The two groups who would be the most difficult to identify would be those who were not receiving any services and those receiving private medical care.

The question of the confidentiality of such information, however, must be answered before any such information system is developed.

The existing sources of information for identifying developmentally disabled individuals include:

1. Birth Records: Congenital anomalies show up within a few days in about 1% of live births. Those appearing later would, of course, not be noted on birth records. The Health Department estimates that the percent of such defects rises to 4-5% by the end of the first year of life.
2. Public Health Nurse Reports: Seventy-six of the 87 counties in Minnesota have organized public-health nurse services; these could potentially be involved in a reporting system.
3. Records of the child-development centers at Owatonna and Fergus Falls.
4. Records of the Crippled Children's Clinics operated by the Department of Welfare.

5. Private Associations: The private associations for the retarded, cerebral palsied, and epileptic are all striving to contact families with developmentally disabled children early in order to help them use available services. These efforts are most successful in those areas of the state with local chapters of these organizations, particularly where an office is maintained.

6. Schools: As improvements are made in needs-assessment surveys and school-census information throughout the state, more children who need special services will be identified, and the nature of their needs will be better known. The requirement for schools to report the reasons for not serving individual children in their districts may also help identify severely disabled children for whom local resources are inadequate.

7. Operating Programs: The majority of developmentally disabled persons probably have come to the attention of one or more public or private agencies and consequently appear in some fashion in their records. However, there is no adequate way to combine this information, either for planning purposes or to ensure that individuals who need services come to the attention of appropriate public or private programs.

Chapter 7. AGENCY COMMENTS

All those interviewed in the preparation of this study of Minnesota programs were asked to identify problems they saw within the network of public and private agencies and to suggest functions and priorities for the Council. There is naturally a great deal of overlap between these two lists, but they are presented separately to avoid burying valuable suggestions.

7.1 Council Functions

Three major objectives of the Council were proposed:

1. Council should play a policy-making role, with implementation to be left to existing or new agencies.
2. Council should act as a coordinating body among state and private agencies.
3. The limited funds available should be used to develop experimental programs rather than to supplement existing programs.

Many of those interviewed were concerned about the limited funds. Nearly all hoped for regular feedback from the Council on its progress and plans.

Several agencies not now represented on the Council suggested that they be included.

7.2 Specific Objectives

The first three suggestions on the following list were mentioned frequently as high-priority needs:

- increased work activity centers,
- long-term sheltered workshops, and
- community residences for adults.

Other suggestions for the Council follow:

- consider a broad range of disabilities beyond the strictly defined categories of P.L. 91-517;
- in contrast to above, place more emphasis on categorical diseases;
- stress rural needs, since urban programs are relatively satisfactory;
- act as advocates for the disabled persons in Minnesota;
- set up incentives for industry to provide jobs for disabled persons;
- develop evaluative criteria for programs as well as general policy guidelines;
- develop more regional planning;
- identify an appropriate focus in state government for planning and programming in the area of mental retardation;
- establish a state-wide developmental-disabilities identification service;
- identify defects in current program;
- centralize information and referral procedures;
- involve private agencies to a greater extent, especially in pilot program activity;

- hold hearings with "key" people within the state to expand Council information concerning active programs and needs;
- establish concrete priorities for the developmental disabilities program and actively solicit proposals from state and private organizations to accomplish priority goals;
- retain some monies for direct Council use so that all activity need not depend on voluntary time.

7.3 Problem Areas

Several of the following problems were identified by a number of those interviewed:

- prevention — inadequate attention is given to preventing disablement;
- comprehensive evaluation — total program planning is needed for all developmentally disabled individuals with adequate means for periodic and regular updating of the individualized plan;
- early intervention — more services need to be provided at an earlier time to be most effective;
- outreach — few programs are effective in outreach efforts, consequently some groups are less adequately reached than others, especially in rural and urban poverty areas;
- coordination -- this problem exists at the departmental level, where there is no mechanism for broad coordination, and at the individual level, where services lack continuity and are fragmental;
- planning — more planning needs to be done at the local and regional levels;

- regional services -- more services need to be provided at the regional levels;
- cost of services are a particular burden for middle-income families and county governments;
- advocacy services are needed, particularly for individuals;
- duplication of services — particularly diagnostic services -- should be cut down.

Agencies were asked to list gaps in services of which they were aware; these gaps included:

- preschool services,
- vocational training both for secondary students and adults,
- services for the seriously emotionally disturbed,
- services for the home bound handicapped,
- services for developmentally disabled young offenders,
- day activity centers,
- special education classes (22,000 developmentally disabled are not currently served),
- residential facilities,
- child-development centers,
- assistance for persons who are returning to their communities from institutions.

APPENDIX A

BIBLIOGRAPHY OF REPORTS RELATED TO DEVELOPMENTAL DISABILITIES

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Anderson, Governor Wendell R. "Proposed Biennial Budget 1971-1973 Program Budget Supplement, Department of Education." January 1971 St. Paul, Minnesota.

Bright, Farley D. "Guidelines for School Excuse, Exclusion, and Expulsion (Demissions)." MEMORANDUM November 1971 State of Minnesota, Department of Education, St. Paul, Minnesota.

Capitol Association for Retarded Children. "Citizen Advocate Program Pilot Project." Ed. Mrs. Leola J. Novak, Lincoln, Nebraska May 1971.

Chorn, E. J. "Annual Statistical Report - Part I" DEPARTMENT OF EDUCATION, DIVISION OF VOCATIONAL REHABILITATION November 1971 St. Paul, Minnesota

Dawis, Rene V. "Estimates of Disability in Minnesota" July 1970. Report prepared under a contract for Consultant Services with the Division of Vocational Rehabilitation, Minnesota State Department of Education

Deno, Evelyn. Chairman Advisory Board on Handicapped, Gifted and Exceptional Children. "1970 Annual Report to the State Board of Education, Governor's Statutory Advisory Board on Handicapped, Gifted and Exceptional Children."

Donovan, Joseph L. THE MINNESOTA LEGISLATIVE MANUAL 1969-1970. The State of Minnesota at St. Paul.

Heber, R. A. "A Manual on Terminology and Classification in Mental Retardation." (2nd ed.) AMERICAN JOURNAL OF MENTAL DEFICIENCY, 1961. (Monograph Supplement)

Hoyt, John S. Jr. REGIONAL DEVELOPMENT SYSTEMS IN MINNESOTA University of Minnesota, Agricultural Extension Service, Minnesota State Planning Agency.

Keenan, W. W. 1968 DIRECTORY OF REFERRAL AND REHABILITATION RESOURCES IN MINNESOTA Minnesota Department of Education, St. Paul, Minnesota.

Minneapolis Rehabilitation Center, Inc. "Rehabilitation in Minnesota - A Legislative Study." October 1970.

Minnesota Comprehensive Health Planning Agency. "Planning Study for Residential Care in Minnesota." September 1968. Stanford Research Institute, Menlo Park, California.

Minnesota Department of Corrections. "A Comprehensive Plan for Regional Jailing and Juvenile Detention in Minnesota." FINAL REPORT January 1971.

Minnesota Department of Corrections, Division of Research and Planning, "Characteristics of Populations Under Supervision of the Institutions and Field Services." May 1970.

Minnesota Department of Education, "School Excuse, Exclusion, and Expulsion. Guidelines and Directions" 1971. Minnesota Department of Education, Division of Planning and Development "Projects to Advance Creativity in Education. E.S.E.A., Title III in Minnesota.

Minnesota Department of Education, Division of Vocational Rehabilitation, "A Review and Analysis of Six Recently Conducted Vocational Rehabilitation Studies." May 1971 Stanton Associates, Inc., St. Paul, Minnesota.

Minnesota Department of Health. "Maternal and Child Health Activities Including Especially Requested Topics from other Local and State Agencies and Organizations." ANNUAL NARRATIVE REPORT FY 1971.

Minnesota Department of Health. "Minnesota Department of Health Organizations and Functions."

Minnesota Department of Public Welfare, Division of Child Welfare, "Title IV Plan Services to Families and Children." May 1969. Minnesota Department of Public Welfare, St. Paul, Minnesota.

Minnesota Department of Public Welfare, Medical Services Division, Community Programs Section. "1970-1971 Directory of Minnesota Community Mental Health-Mental Retardation Area Programs." St. Paul, Minnesota.

Minnesota Department of Public Welfare, Medical Services Division. "The Minnesota State Plan for Comprehensive Community Mental Health Centers Construction 1969." St. Paul, Minnesota.

Minnesota Department of Public Welfare. "Mental Retardation Facilities Construction Plan Biennial Revision December 1969." St. Paul, Minnesota.

Minnesota Mental Retardation Planning Council. "A Comprehensive Plan to Combat Mental Retardation in the State of Minnesota." Volumes I and II. April 1966. St. Paul, Minnesota.

Minnesota, State of. "Appendix Final Report of Comprehensive Statewide Planning for Vocational Rehabilitation Services." July 1967-July 1969. University of Wisconsin Regional Rehabilitation Research Institute.

Minnesota, State of. "Comprehensive Plan for Mental Health Services P.L. 89-749 314 (d) 1969-1970." Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, Arlington, Virginia.

Minnesota, State of. "Comprehensive Plan for Mental Health Services P. L. 89-749 314 (d) 1969-1970 Revised Draft." November 1969. Department of Health, Education and Welfare, Public Health Service, Health Services and Mental Health Administration, Arlington, Virginia.

Minnesota, State of. Department of Education. "Minnesota State Plan for Vocational-Technical Education." Part I, II, III. July 1971. State of Minnesota, Department of Education, St. Paul, Minnesota.

Minnesota, State of. Department of Public Welfare Retardation Services Division. "Program Plan - Draft Copy." October 1971.

Minnesota, State of. Public Welfare Facilities Committee. "Hoffman Report."

Minnesota, State of. Task Force on Behavioral Disabilities. "Behavioral Disabilities."

Minnesota State Board of Health. "Minnesota Vital Statistics, 1969." Minnesota Department of Health, Minneapolis.

Minnesota State Planning Agency. "Final Report of Comprehensive Statewide Planning for Vocational Rehabilitation Services." September 1969. St. Paul, Minnesota.

Minnesota State Planning Agency. "Public Welfare Regional Facilities Report." July 1970. State of Minnesota, St. Paul, Minnesota.

Minnesota State Planning Agency. "State Policies Plan for the Provision of Residential Care." December 1968. St. Paul, Minnesota.

Rosenfield, A. B. A Preliminary Evaluation of Hennepin Anoka Pilot Project for Follow-up of "High Risk Mothers and Infants," HMSC Bulletin, Volume II, August 1971.

Teeter, Richard R. "St. Paul-Ramsey County Mental Health Center." APPLICATION FOR GRANT-IN-AID FISCAL YEAR 1969-1970.

United States Government, Department of Health, Education, and Welfare. "Architectural Guidelines. Minimum Standards for Design, Construction, and Equipment of Facilities for Persons with Developmental Disabilities." SRS/RSA PUBLICATION NO. 179. (Tentative) August 1971.

United States Government, Department of Health, Education, and Welfare. (45CFR Part 416), "Developmental Disabilities Program. Notice of Proposed Rule Making." Draft 6-8-71.

United States Government, Department of Health, Education, and Welfare. "Minimum Standards - Services and Programs for Developmentally Disabled Persons." Developmentally Disability Services and Facilities Act of 1970." (P.L. 91-517) (Tentative) September 1971.

United States Government, Department of Health, Education, and Welfare. "State Plan Guidelines. Developmental Disabilities Services and Facilities Construction Act of 1970." (P.L. 91-517) (Tentative) June 1971.

United States Government, Public Law 91-517. 91st Congress, S. 2846. October 30, 1970. "Developmental Disabilities Services and Facilities Construction Amendments of 1970."

Minnesota Department of Education, Division of Vocational Rehabilitation. "Division of Vocational Rehabilitation State Plan."

APPENDIX B

LETTERS AND QUESTIONNAIRES

STATES OF MINNESOTA

OFFICE OF THE GOVERNOR

WENDELL R. ANDERSON **ST. PAUL.**
55101

GOVERNOR

November 8, 1971

I request your assistance in helping the Governor's office to develop our state plan for implementation of the Developmental Disabilities Services and Facilities Construction Act (P.L. 91-517).

In order to review current activities, we have entered into a contract with the Institute for Interdisciplinary Studies under which they will act as staff support to Mr. W. Dennis Pederson.

Doctor James Wiechers, Mrs. Corrine Larson, or Mr. Gary Prazak of the Institute will be contacting you for time in which to conduct interviews concerning your current program, projected plans, and thinking for dealing with the developmental disabilities as described in Federal legislation.

I hope that you will cooperate with these individuals and direct them to the persons in your organization who can provide the appropriate information.

Sincerely,

Wendell R. Anderson
GOVERNOR

/dlh

Institute for Interdisciplinary Studies

123 East Grant Street, Minneapolis, Minnesota 55403 / telephone (612) 338-8761

James E. Wiechers, Ph.D.
Director, Educational and Occupational Research Division

November 12, 1971

As you know the Governor's office has signed a contract with the Institute for Interdisciplinary Studies to gather information for the State Planning and Advisory Council for Developmental Disabilities.

Corrine Larson, Gary Prazak, or I will be calling soon to set up an interview appointment(s) with you and/or others whom you select. We are interested in what is now being done and in what is being planned for the Minnesota residents who have mental retardation, cerebral palsy, epilepsy, or related neurological disabilities which are treated like mental retardation.

Information is being gathered from each of the state departments, voluntary agencies, and organizations involved with the disability groups named above. The attached questions are a guide to the areas which must be covered, but are not meant to restrict the interview if there are additional areas you would like to see covered. We are also interested in any source documents, studies, or reports you may have developed which answer these questions. A summary of the legislation is also enclosed for your interest.

An interview summary will be returned to you for approval before the report to the Advisory Council is assembled. Our work must be completed by December 20, so we will be contacting you in a few days.

Sincerely,

James E. Wiechers, Ph.D. Director,
Educational and Occupational Research
Division

JEW/sh

Enclosures

DEVELOPMENTAL DISABILITIES

INTERVIEW FORM FOR PUBLIC AGENCIES

I. General Information

Agency

Address

Interviewee

Title

Phone Number

Interviewer

Date

II. Agency Structure

A. Describe district or regional structure, planning areas, service areas, etc.

B. Are you carrying out efforts related to federally assisted programs concerned with the education of the handicapped, vocational rehabilitation, public assistance, medical assistance, social services, maternal and child health, crippled children's services, comprehensive health, and mental retardation? Describe.

III. List programs or projects related to mental retardation, cerebral palsy, epilepsy, as covered by the Developmental Disabilities Legislation.

IV. Program Description

Name of Program .....

Objective(s) a.

b.

c.

How long has this program been operating?

A. Population

1. List the eligibility criteria for program (client characteristics, certification or referral from another agency, etc.)

2. Total number of clients in this program last fiscal year

3. Percentage of mental retardation, cerebral palsy, epilepsy and other Developmental Disabilities clients served last (fiscal)year

4. Is program specific to those disabilities or are clients mixed? How?

5. Estimate total Developmental Disabilities to be served this current year

6. Total who requested but did not receive services

7. List categories and percentage of those requesting but not receiving services

8. Estimated total who could benefit from program (please provide source of information)

9. Client characteristics (please provide source documents)
   1. Age
   2. Sex
   3. Disability category
   4. Severity of disability
   5. Service needs
   6. Other

10. List the most frequent sources of referral to this program

11. In cases of multiply handicapped clients, how do you record the handicaps?

12. What percentage of the developmentally disabled in this program are concurrently involved in the following other programs? Estimated or documented?

____ DVR

_____ Employment Services

_____ Welfare

_____ Special Education

_____ Medical and Related Services

_____ Vocational Rehabilitation Facilities

_____ Sheltered Workshops

_____ Day or Work Activity Programs

_____Other (specify)

13. Are modifications in eligibility requirements or program content now being planned which will substantially change any of the above information? If yes, specify the modifications, the areas of impact, and the expected effects.

B. Services

1. Describe the services offered by each program (major services areas include medical, educational, vocational, social, personal, etc.) Indicate which services are provided, which are purchased, and which are referred.

2. Are these services available to everyone in the program who needs them? What proportion of the developmentally disabled get them? How is need determined?

C. Program Evaluation

1. What criteria are used to judge success or failure of the program?

2. Results of program Number of successes Number of failures Number of drop outs during program

3. What cost/benefit information do you have? How is it calculated?

4. Do you follow up clients on an ongoing basis? Periodic studies? Describe.

5. What information do you have on the stability of results achieved?

D. Staff

For each program listed in Part II concerned with Developmental Disabilities, please provide the following information and documentation of any figures.

1. Total and full time equivalent staff providing direct client services (based on the amount of time a person spends on direct services). A full-time staff member who only works part time in direct services should be counted as part time.

2. List job titles of staff providing direct client services, total and full time equivalents, number of positions for each title, and educational requirements of each

Title	Total	Full Time Equivalent

3. Total and full time equivalent other staff

4. How is staff selected for each job title?

5. Are any modifications in the program now being planned which will substantially change any of the above information? If yes, specify the modification, areas of impact, and the expected effects.

E. Budget

For each program please provide the following information and documentation of any figures.

Program

1. Source(s) of funds

Federal	State	Other

2. Expected continuity of each

Federal	State	Other

3. Dollar amount spent on services for the developmentally disabled.

4. What restrictions does the funding agency place on expenditures?

5. Are there any budget modifications now being planned which would substantially change any of the above information? If yes, specify modifications, areas of impact, and expected effects.

6. If more money were available, what changes would you make in the following areas for the developmentally disabled? What barriers would there be to the changes and how long would the changes take?

   a. Staff

      number

      type

   b. New services

   c. Expansion of existing services

   d. Outreach - case finding

   e. Policies and procedures

   f. Legislative change

   g. Other

V. Information and Referral

Do you provide information and/or referral services to the Developmentally Disabled?

1. Do you have specific staff assigned to these tasks? Number, type.

2. What specific procedures and forms do you use?

3. What constitutes a referral by your organization?

A. Do you contact agencies directly by mail or phone in making a referral?

5. Do you follow up on referrals made? How? In what percent of cases?

6. What percent of your referrals are accepted for services?

7. Do you have a community resource handbook?

8. To which agencies or types of agencies do you most frequently refer people? How many people? For what services?

9. What problems do you have in providing a referral service?

VI. Planning

A. Management Structure

1. Describe the management structure of the agency for planning purposes.

2. Does the agency have an advisory committee? What are its functions?

3. How does planning in your agency relate to planning in other agencies which service some of the same clients?

B. Information (Copies of source documents, sample tabulations)

1. Do you have information on the incidence of the developmentally disabled in your area?

   a. What is the source of this information?

   b. How would you evaluate the quality and reliability of the infor?

   c. Is this information useful to your agency?

   d. How do you use it?

   e. Is there additional information about incidence that would be useful to your organization? What?

2. Do you collect or use information about the Developmentally Disabled in the population at large in your area? Such information as sex, age, race, health status, housing, educational status, severity of disability, etc.

   a. What is the source of this information?

   b. How would you evaluate the quality and reliability of the infor?

   c. Is this information useful to your agency?

   d. How do you use it?

   e. Is there additional information about incidence that would be useful to your organization? What?

3. Do you have information of the service needs of the Developmentally Disabled statewide? Regionally? Describe.

   a. What is the source of this information?

   b. How would you evaluate the quality and reliability of the infor?

   c. Is this information useful to your agency?

   d. How do you use it?

   e. Is there additional information about incidence that would be useful to your organization? What?

A. How do you collect information about the Developmentally Disabled that receive services from your agency? (Source documents)

   a. services provided

   b. results achieved

   c. reasons for non-completion or failure

   d. other

5. What management decisions do you make?

6. How do you use all these kinds of information to make decisions about changing, expanding, or redirecting your program? Give specific examples.

7. Do you share information you develop with others? Who?

8. What information would you like to have to improve the planning or evaluation of your activities?

9. How adequate do you feel the information used by public and private agencies which provide services is for planning and resource allocation purposes? What additional information is needed?

10. What are your federal and/or state reporting requirements?

VII. Advocacy

A. Description of advocacy services in programs dealing with Developmental Disabilities. 1. Type of advocacy a. Individual

1) Encourage persons to use existing community resources.

2) Provide information to a potential consumer concerning the types of services available.

3). Provide information to potential consumers of a specific service concerning the quality of that organization.

4) Inform persons about their legal rights of obtaining services from an organization.

5) Refer persons to community resources.

6) Act as an advocate for a specific person to insure that he is accepted for services, and that he will obtain a reasonable benefit.

7) Follow-up persons referred to a resource to determine if the recipient is satisfied with the services and the result.

8) Other. describe.

b. Agency

1) Getting an organization to modify or change legal but abusive and discriminatory policies, practices and procedures (hiring restrictions, workmanship, overpricing, poor quality of services, etc.)
2) Working with an organization to insure that they abstain from illegal practices such as discriminatory acts, environmental abuses, etc. (e.g., legal compliance).
3) Provide consultation or technical assistance to an organization which will improve the performance of the organization.
4) Raise funds for an organization.
5) Assist similar or related organizations to plan cooperative programs, coordinate services, etc.
6) Attempt to get legislation passed which would create new resources, improve funding, provide better regulation, improve services, etc.
7) Other. describe.

B. Do you provide advocacy services in the field of Developmental Disabilities? List and describe each type. (see list of types of advocacy)

1. Type and number of staff providing service

2. Tasks involved in providing the service, specific.

3. Is money budgeted specifically for this service? amount? source?

4. Number of persons requesting the service last year?

5. Examples of problems, that the clients had that led up to the advocacy service.

6. What are the characteristics of the people you help in this way? what are their needs?

7. What effect, impact, has this program had on disabled individuals? How is this determined?

8. What effect has the program had on your organization?

9. What effect has the advocacy program had on other organizations and agencies? (including governmental and legislative)

10. What effect has the advocacy program had on public opinion?

C. It is assumed that the purpose of advocacy programs is to represent the "best interests" of the client. How are the "best interests" of the Developmentally Disabled, determined?

D. What problems have come up in setting up and running the program?

E. What are the strongest and the least effective aspects of your advocacy program? Explain.

F. Do you plan any changes in your advocacy programs in the near future? Explain.

G. What do you think are the advocacy needs of the Developmentally Disabled?

H. Do you know of any advocacy programs related to the Developmentally Disabled?

1. Which ones are particularly effective? Why?

2. Which ones are not? Why?

VIII. Agency Interaction (please disregard your own agency)

A. Which of the following agencies and organizations does this agency maintain regular contact with in carrying out programs. Describe formal and informal arrangements.

1. State Department of Corrections

Formal

Informal

2. State Department of Education (specify division)

Formal

Informal

3. Minnesota Department of Health (specify Division)

Formal

Informal

A. Minnesota Department of Manpower Services

Formal

Informal

5. Minnesota Department of Public Welfare (specify division)

Formal

Informal

6. Minnesota State Planning Agency

   Formal

   Informal

7. Governor's Commission on Employment of the Handicapped

   Formal

   Informal

8. Minnesota Rehabilitation Association

   Formal

   Informal

9. Minnesota Administrators of Special Education

   Formal

   Informal

10. Minnesota Association for Retarded Children

    Formal

    Informal

11. Minnesota Epilepsy League

    Formal

    Informal

12. United Cerebral Palsy of Minnesota

Formal

Informal

13. Minnesota State Medical Association

Formal

Informal

14. Minnesota Association of Rehabilitation Facilities

Formal

Informal

15. Governor's Advisory Board on Handicapped, Gifted, and Exceptional Children.

Formal

Informal

16. Minnesota Association for Children with Learning Disabilities.

Formal

Informal

17. Minnesota Association of Mental Health Programs

Formal

Informal

B. What problems do you see within the network of public and private agencies serving the developmentally disabled? Explain. 1. Prevention

2. Outreach (potential recipients not informed of available services)

3. Services not geared to needs

4. Gaps in services

5. Problems of coordination

6. Availability of services

7. Under utilization of services

8. Timing of services

9. Duplication of services

10. Overlapping jurisdiction

11. Cost of services

12. Local planning

13. Other (specify)

What are some possible solutions to these problems?

How might public and private groups works together more effectively?

IX. General Information

A. From the perspective of your agency what do you think should be the major objectives of the Governor's Advisory Committee on Developmental Disabilities?

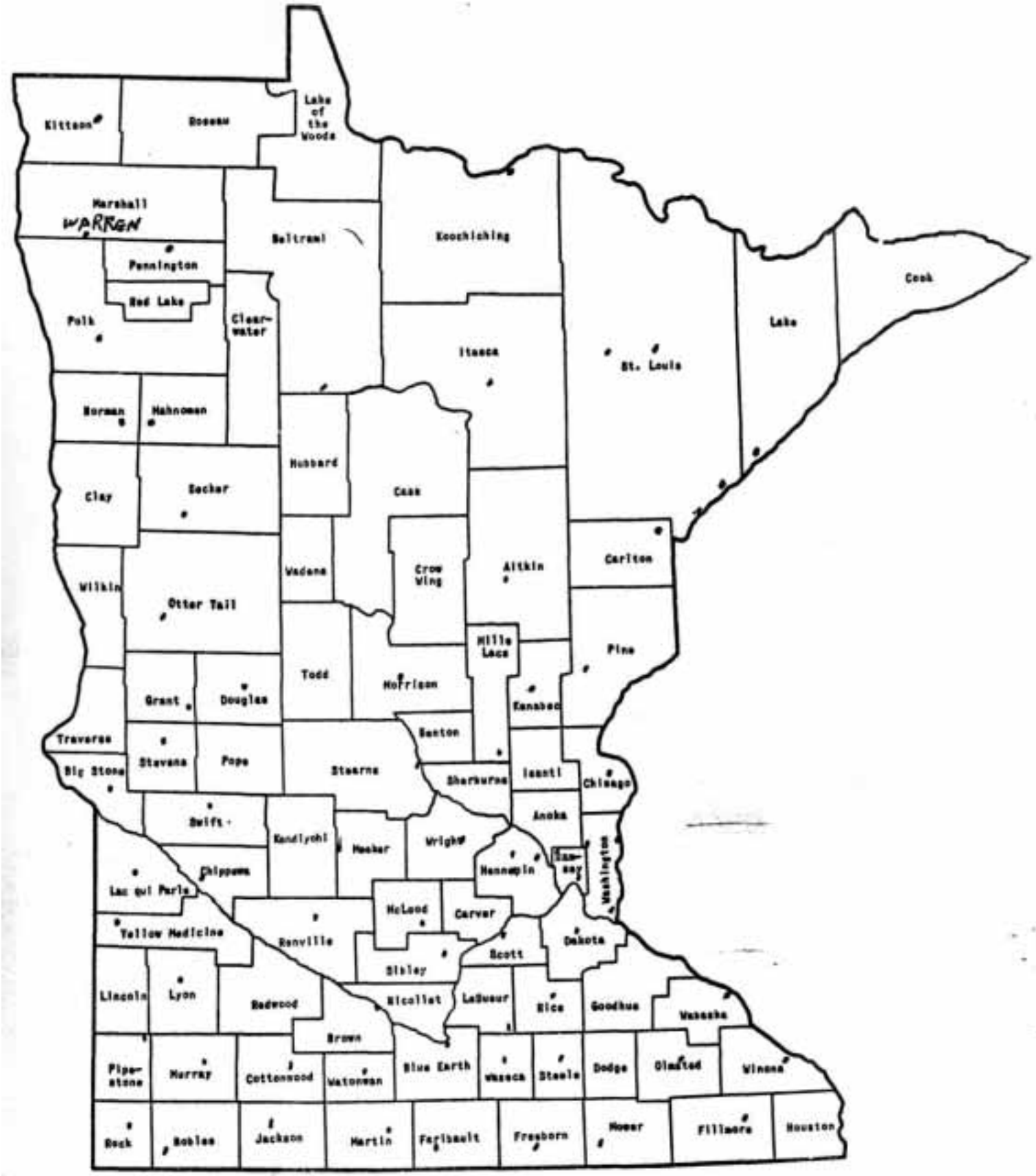
B. What effect do you expect Developmental Disabilities legislation to have on your agency?

C. With limited new money available in the near future for improving and/or expanding services and facilities what do you feel are the ones most needed? Which would you give highest priority? Why?

D. Do you have any other information, comments, or suggestions that you think should be considered by the Governor's Advisory Council in its planning?

APPENDIX C

DAYTIME ACTIVITY CENTERS 1971-72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Koochiching
Cook
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Pennington
Red Lake
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Clear-water
Itasca
St. Louis
Norman
Mahnomen
Hubbard
Cass
Clay
Becker
Wilkin
Otter Tail
Wadena
Crow Wing
Aitkin
Carlton
Pine
Todd
Morrison
Mille Lacs
Kanabec
Grant
Douglas
Traverse
Stevens
Pope
Big Stone
Stearns
Benton
Sherburne
Isanti
Chisago
Swift
Kandiyohi
Meeker
Wright
Anoka
Hennepin
Ramsey
Washington
Chippewa
Lac qui Parle
McLeod
Carver
Yellow Medicine
Renville
Scott
Dakota
Sibley
Lincoln
Lyon
Redwood
Nicollet
LeSueur
Rice
Goodhue
Wabasha
Brown
Pipe-stone
Murray
Cottonwood
Watonwan
Blue Earth
Waseca
Steele
Dodge
Olmsted
Winona
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston

DAYTIME ACTIVITY CENTERS 1971-72

1. Aitkin County DAC
   506 Minnesota Ave. No.
   Aitkin, Minn.65431

   Satellite Center: Big Sandy Lake

   Director: Paul Kellerman
   Chairman: Norman Andresen

2. All Saints DAC
   15915 Excelsior Blvd.
Minnetonka, Minn. 55343

Director: Mrs. Maxine Opheim Co-Dir.: Mrs. Shirley Maruska
Chairman: Pastor Robert Warren

3. Alpha Center
   311 E. Clark St.
   Albert Lea, Minn. 56007

   Director: Mrs. A. C. Graham
   Chairman: Rev. Clemet Haley

4. Anoka County DAC
   6120 NE 5th St.
   Fridley, Minn. 55421

   Satellite Center: 1415 6th Ave. S.
   Anoka, Minn. 55303

Director: Mrs. Catherine Molick Chairman: Michael O'Bannon

5. Austin Activity Center, Inc.
P.O. Box 531 Austin, Minn. 55912

   Director: Douglas Koons
   Chairman: Robert Schulz

6. Becker County DAC Box 852
Detroit Lakes, Minn. 56501

   Director: Mrs. Judy Thorson
   Chairman: Mrs. Mary Florence Parker

7. Beltrami County DAC
   523 - 19th St.
   Bemidji, Minn. 56601

   Director: Arvilla Reichert
   Chairman: Miss Mary Foster

8. Benton, Sherburne, Mille Lacs DAC
   RR #1
   Princeton, Minn. 55371

   Director: Mrs. Ezra Angstman
   Chairman: Mrs. Bernadyne Sykora

9. Big Stone County DAC
   IOOF Building
   Clinton,. Minn. 56225

   Director: Mrs. Betty Schwarze
   Chairman: Mrs. Idyll George

10. Brighter Day Activity Center
    500 S. Walnut
    Mora, Minn. 55051

    Director: Mrs. Loretta Stanton
    Chairman: Everett Taylor

11. Canby Activity Center
    108 Haarfager N.
    Canby, Minn. 56220

    Director: Mrs. Leola Ruth
    Chairman: Richard Olson

12. Carver County DAC
    Rt. #1, Box 584P
    . Excelsior, Minn. 55331

    Director: Byron L. Quinn
    Chairman: Mrs. Lil Cooper

13. Children's Harbor School
    Box 844
    Moorhead, Minn. 56560

    Director:
    Chairman: Virgil E. Brogren

    Operate 2 centers

14. Chippewa County DAC
    526 State Road
    Montevideo, Minn. 56265

    Director: Mrs. Inger Olien
    Chairman:

15. Chisago County DAC
    Box 709
    Lindstrom, Minn. 55045

    Director: Miss Carol Cleary
    Chairman: Rev. Gordon R. Grimm

16. Community Involvement Programs
83 So. 12th St. Minneapolis,
Minn. 55403

Director: William Funari
Chairman: Thomas Zemek

17. Christ Child Services, Inc.
2078 Summit Avenue
St. Paul, Minn. 55105

Director: Sister Madeleva
Chairman: Charles E. Rea

18. Curative Workshop
1800 Chicago Ave.
Minneapolis, Minn. 55404

Director: Mrs. Phyllis Rodrick
Chairman: David Wyer

19. DACs of Minneapolis, Inc.

Open Door DAC 2314 Elliot Ave.
So. Minneapolis , Minn. 55404

Friendship DAC
2730 East 31st St.
Minneapolis, Minn. 55406

Coordinator: Dianna Krogstad
Chairman: Howard Paulsen

20. Dakota County DAC
Box 400
Rosemount, Minn. 55068

Director: Lon Miller
Chairman: Mrs. Doris Tanke

21. Dale St. Pre-School Center
25 No. Dale St.
St. Paul, Minn. 55102

Director: Mrs. Alice Bloedoorn
Chairman: Mrs. Richard Ogorek

22. Douglas County DAC
P.O. Box 216
Alexandria, Minn. 56308

Director: Mrs. Beth Widem
Chairman: Mrs . Mary Norlinger

23. Duluth Sheltered Workshop 310
Lake Avenue So. Duluth,
Minn. 55802

Director: Mrs. Carol Olson
Chairman: Dr. William C. Atmore

24. East Range DAC, Inc.
Box 644
Eveleth, Minn. 55734

Director: Mrs. Frances Johnson
Chairman: Thomas Vukelich

25. Falls DAC
P.O. Drawer C
Thief River Falls, Minn. 56701

Director: Evan Armstrong
Chairman: Art Heinze

26. Faribault County DAC
7th & Holland
Blue Earth, Minn. 56013

Director: Lyle Bailey
Chairman: Glenn Binfield

27. Fillmore County DAC
Sons of Norway Bldg.
Lanesboro, Minn. 55949

Director: Mrs. Nellie Erickson
Chairman: Carl Kohlmeyer

28. Fraser School, Inc.
2400 West 64th St.
Minneapolis, Minn. 55423

Satellite:W. 60th & Nicollet

Director: Robert J. Kowalczyk
Chairman: Rev. H. T. Rasmussen

29. Freeborn County DAC, Inc.
308 Water St.
Albert Lea, Minn. 56007

Director: Frank Cuden
Chairman: John Chesterman

30. Granite Falls DAC, Inc.
210 - 9th Ave.
Granite Falls, Minn. 56241

Director: Ranee Walstrom
Chairman: Clifford Holth

31. Grant County DAC
Bethel Lutheran Church
Hoffman, Minn. 56339

Director: Mrs. Lillian Anderson
Chairman: Rev. John Dehaan

32. Green Haven Heights Community DAC
1909 E. Ivy Ave. St. Paul, Minn. 55106

Director: Ray Kelly Chairman: Dr. Christian Zaun

33. Hammer School, Inc.
1909 E. Wayzata Blvd.
Wayzata, Minn. 55391

Director: Miss Evelyn Carlson
Chairman:

34. Hennepin County DAC
1701 Oak Park Ave. No.
Minneapolis, Minn. 55411

Director: Miss Patricia Findley
Chairman: Mrs. Gayle Adelsman

35. Holy Nativity DAC
3540 Winnetka Ave. No.
Minneapolis, Minn. 55427

Director: Mrs. Annette Weinberg
Chairman: Alfred Morin

36. Hope DAC
Ruthton, Minn. 56170

Director: Mrs. Ethel Sether
Chairman: James Kroening

37. Itasca County DAC
Coleraine, Minn. 55722

Director: Mrs. Faith Wick
Chairman: George Cassell

38. Jackson County DAC 412
Broadway Ave.
Lakefield, Minn. 56150

Director: Mrs. Nancy C. Pietz
Chairman: James Moller

39. Kandi-Meeker DAC
Atwater, Minn. 56209

Director: Mrs. June Monson
Chairman: Elroy Lovander

40. Kaposia Area DAC 179 E.
Robie •St. Paul, Minn.
55107

Director: Dianne Fagen
Chairman: Ronald Finnegan

41. Kittson Count DAC, Inc.
Lake Bronson School
Lake Bronson, Minn. 56734

Director: LaVerne Nyflot
Chairman: Victor Johnson

42. Lac Qui Parle County DAC, Inc.
Box 38
Madison, Minn. 56256

Director: Mrs. Bernice A. Karels
Chairman: Mrs. Martha McKenney

43. Lake County DAC, Inc. P.O.
Box 252 Two Harbors,
Minn. 55616

Centers located: Knife River
Silver Bay

Director: Mrs. Melanie Handsaker
Chairman: Don Carroll

44. Lyon County DAC
501 S. Whitney St.
Marshall, Minn. 56258

Director: Mrs. Helen Peterson
Co-Dir.: Mrs. Katherine Pottorf
Chairman: Mrs. Vernon Runholt

45. Laurel DAC, Inc.
1895 Laurel Ave.
St. Paul, Minn. 55104 ..

Director: Anna Fandel
Chairman: Wayne Sandberg

46. LeSueur County DAC
415 West Lake St.
Waterville, Minn. 56096

Director: Mrs. Carolyn Engquist
Chairman: Mrs. Bonnie Wieland

47. McLeod County DAC • .
Route 3
Glencoe, Minn. 55336

Director: Mrs. Norma Syverson
Chairman: William C Hochsprung

48. Mahnomen County DAC
First Lutheran Church
Mahnomen, Minn. 56557

Director: Ray Spilde
Chairman: Mrs. Florence Janousel

49. Mankato Rehabilitation Center
P.O. Box 818 Mankato, Minn.
56001

Director: Katherine Garity
Chairman: John Maiers

50. Marshall County DAC, Inc.
228 East Johnson
Warren, Minn. 56762

Director: Mrs. Dolores Bienek
Chairman: Leonard Olson

51. Martin County DAC
P.O. Box 467
Sherburn, Minn. 56171

Director: Mrs. Audrey Nelson
Chairman: Lester E. Madsen

52. Merriam Park DAC
2000 St. Anthony Avenue
St. Paul, Minn. 55104

Director: Stuart Weitzman
Chairman: Mrs. Charles Rea

53. Merrick DAC
715 Edgerton St.
St. Paul, Minn. 55101

Director: Roger Hacker
Chairman: Mrs. Mary Charpentier

54. Midway Learning & Mfg.
771 Raymond Ave.
St. Paul, Minn. 55114

Exec. Dir.: John Durand
Prog. Dir.: Bill Carlson
Chairman: H. W. Teichroew

55. Model Neighborhood DAC
3045 Chicago Ave. So.
Minneapolis, Minn. 55407

Director: Dorothy Mollien
Chairman: Allan Bostelmann

56. Morrison County DAC, Inc.
317 W. Broadway
Little Falls, Minn. 56345

Director: Martin L. Nier
Chairman: "Robert Manning

57. Mt. Olivet DAC
5025 Knox Ave. So.
Minneapolis, Minn. 55419

Director: Mrs. Lily Yarosh
Chairman: Mrs. Roland Rasmussen

58. Murray County DAC
28th and Maple
Slayton, Minn. 56172

Director: Mrs. Shirley Reedy
Chairman: John Barnett

59. Nat G. Polinsky Mem. Rehab. Ctr.
530 East 2nd St.
Duluth, Minn. 55805

Director: Mary E. Van Gorden
Chairman:

60. Nobles County DAC
Adrian Public School
Adrian, Minn. 56110

Director: Mrs. Helen Kramer
Chairman: Judge Vincent Hollarer

61. Norman County DAC
Twin Valley, Minn. 56584

Director: Miss Nancy Hedland
Chairman: Maurice Anderson

62. North St. Paul Children's Center
2675 E. Highway 36
No. St. Paul, Minn. 55109

Director: Miss Jacqueline Sailer
Chairman: Edward Leach

63. North Suburban DAC
3000 No. Hamline Ave.
St. Paul, Minn. 55113

Satellite: 3115 N. Victoria

Director: Mrs. Kay Zwernik
Chairman: Dr. Dewey G. Force

64. Northland DAC
800 - 5th St.
International Falls, Minn.
56649

Director: Chrystal Clance
Chairman: Elvryn K. Boe

55. Northome DAC
Mission Covenant Church
Northome, Minn. 56661

Director: Marie Killmer
Chairman:

56. Olmsted County DAC Assisi
Heights Rochester, Minnesota
55901

Director: Mrs. Shaw Didier
Chairman: David Dunn

67. Open Arms DAC, Inc.
929 No. Fourth
Mankato, Minn. 56001

Director: Dorothy Adolphson
Chairman: Mrs. Donald Quirin

68. Opportunity Workshop, Inc. DAC
6025 Eden Prairie Eden Prairie,
Minn. 55343

Director: Myron Nirenstein
Chairman: Richard Kauffman

Operate 2 centers

.9. Otter Tail County DAC P.O.
Box 10 Fergus Falls, Minn.
56537

Director: Byron Heggen
Chairman: Carmon Jackson

70. Patterson House DAC
413 Broadway Cloquet,
Minn. 55720

Director: Mrs. Elizabeth Hennum
Chairman: Robert Minor

71. Pine County DAC
United Church of Christ
Sandstone, Minn. 55072

Director: Mrs. Mary Thorvig
Chairman: Mrs. Peggy Cahoon

72. Polk County DAC
Box 113
Crookston, Minn. 56716

Director: Mrs. Bonnie Fokedahl
Chairman: Miss Marian Olson

73. Range Center, Inc.
Box 226
First National Bank Building
Chisholm, Minn. 55719

Exec. Dir.: Sheldon Schneider
Chairman: Leonard Kne

74. Redwood County DAC
Box 23
Clements, Minn. 56224-

Director: Mrs. Mary Jo Boots
Chairman": Duane LeBrun

75. Renville County DAC
907 West Park
Olivia, Minn. 56277

Director: Mrs. Darlene Chan
Chairman: Mrs. Glen Christiansen

76. Research & Development DAC
Hennepin Ave. United Methodist C:
Lyndale and Groveland
Minneapolis, Minn. 55403

Director: Nancy J. Jones
Chairman:

77. Rice County Activity Center
115 NW 3rd St. Faribault,
Minn. 55021

Director: Mr. & Mrs. Richard
Dienst
Chairman: Dr. Wayne Pickell

78. Rock County DAC, Inc.
301 E. Crawford
Luverne, Minn. 56156

Director: Dianne Johnson
Chairman: Raymond Frick

79. Rolling Acres, Inc. Rt
#1, Box 576 Excelsior,
Minn. 55331

Director: Gerald Walsh
Chairman:

80. St. Cloud DAC
302 So. 5th St.
St. Cloud, Minn. 56301

Satellite: Sauk Centre, Minn.

Director: Gretchen Guenther

81.. St. David's Class for Exceptional Children
13000 St. David Road
Minnetonka, Minn. 55343

Director: Mrs. Sybil Lynch
Chairman: Frank 0. Deimel

82. St. Michael DAC 607 So. 26th Ave. Minneapolis, Minn. 554-06

Director: Mrs. Harriet Walsh
Chairman: Sister Anne Joachim Moore

83. St. Paul's on the Hill
1524 Summit Ave. St. Paul, Minn. 55105

Director: Michael J. Corman
Chairman: Rev. T. Ronald Taylor

84. School for Social Development, Inc.
1639 Hennepin Avenue Minneapolis, Minn. 55403

Director: Doris McGregor
Chairman: Kenneth I. Nelson

85. Scott County DAC
Route 1 Jordan,
Minn. 55352

Director: Miss Jeannie Scott
Chairman: Mrs. Marietta Sharkey

86. Sibley County DAC 600
E. Clinton Ave.
Arlington, Minn. 55307

Director: Mrs. Grace Raiter
Chairman: Mrs. Willard Braun

87. Steele County DAC 504
E. School St. Owatonna,
Minn. 55060

Director: Mrs. Elizabeth Hartle
Chairman: Mr. Paul Molstre

88. Stevens County DAC
112 East 6th St. Morris,
Minn. 56267

Director: Mrs. Emmy Kvatum
Chairman: Mrs. Dorothy Zinda

89. Swan Lake DAC
Box 752
Delft, Minn. 56124

Director: Don Pankratz
Chairman: Robert M. Johnson

90. Swift County DAC
10th St. & Oakwood Dr.
Benson, Minn. 56215

Director: Mrs. Sylvia Loy
Chairman.: Ronald Laycock

91.Therapeutic Pre-School of Rehab.
319 Eagle St. St. Paul, Minn. 55102

Director: Lynne Cryer
Chairman: Jack Stryker

92. UCP of Austin DAC
900 - 9th Ave. SW
Austin, Minn. 55912

Director: Mrs. Marian Brown
Chairman: David Swank

93. UCP of Minneapolis DAC
360 Hoover St.
Minneapolis, Minn. 55413

Director: Frank 0. Deimel .
Chairman: Edwin Opheim

94. UCP of St. Paul DAC
463 Maria Ave.
St. Paul, Minn. 55106

Director: Harold Kerner
Chairman: Fredrick Putzier

95. United DAC of Duluth
206 W. 4th St.
Duluth, Minn. 55806

Director: Creighton Koski
Chairman: John Freeman

96. Wabasha County DAC
RR
Wabasha, Minn. 55981

Director: Mrs. Margaret Gisslen
Chairman: Philip A. Gartner

97. Waseca County DAC, Inc. 503
Second Ave. NE Waseca,
Minn. 56093

Director: John L. Fenelon
Chairman: James Slocum

98. Washington County DAC, Inc. (Adm.)
939 W. Anderson St.
Stillwater, Minn. 55082

Chairman: James Scheibe

North Center 425 So. 5th St.
Stillwater, Minn. 55082

Director: Mrs. Nancy Luenzmann

South Center
8839 - 96ft St.
Cottage Grove, Minn. 55016

Director: Mrs. Mary Johnson

99. Watonwan County DAC
307 - 9th St. So. St.
James, Minn. 56081

Director: Mrs. June Poppe
Chairman: Rev. Gilbert Kuyper

100. West Nicollet/Brown DAC, Inc.
P.O. Box 79 New Ulm, Minn. 56073

Director: Roselyn J. Riisness
Chairman: Mrs. Helen Kelly

101. Winona County DAC
365 Main St.
Winona, Minn. 55987

Director: Mrs. Jeanne Cole
Chairman: Margaret Driscoll

102. Wright County DAC
101 NE First Ave.
Buffalo, Minn. 55313

Director: Mrs. Ruth Anderson
Chairman: Rev. Lloyd Sorenson

APPENDIX D

MINNESOTA RESIDENTIAL FACILITIES FOR THE RETARDED

APPENDIX D

Minnesota Residential Facilities for the Retarded - November 1971

There are presently 6,671 children and adults known to the Department of Public Welfare and living in public and private residential facilities. One thousand six hundred sixty-eight of these (25% of total; 656 children and 1,012 adults) live in non-governmental facilities .

In addition to the attached, there are 459 full time foster homes for mentally retarded children. Over the year 1969-70, 1,284 children received foster care in these homes.

CHILDREN'S HOMES	NUMBER OF CHILDREN	CHILDREN'S AGE
Dorothe Lane Children's Home	11	4 thru 11
Pettit Children's Home	20	6 thru 16
Lake View Home	8	Birth to 9
Julie Billiart Home	30	0 thru 6
Champion Children's Home	39	0 thru 12
Cedar Child Care Center, Inc.	30 + 6 temp.	5 thru 12
Welcome Homes, Inc.	43	0 thru 12
The Angels	50	0 thru 8
Vasa Lutheran Home for Children	52	5 thru 19
Roseau Children's Home	85	0 thru 12
Lake Park-Wild Rice Children's Home	48	4 thru 16
Total served	422	

RESIDENTIAL SCHOOLS	NUMBER OF RESIDENTS	AGES
Worthington Cripples Children's School	51	6 thru 21
Mount Olivet Rolling Acres	66	6 thru 31
Hammer School, Inc.	52	5 and over
Laura Baker School	55	4½ and over
Total served	224	

GROUP HOMES	NUMBER OF RESIDENTS	AGES
William Teske Group Home	5	adult
Ewald Poehls Group Home	5	adult
Steve Peleske Group Home	6	adult
Project New Hope, Inc.	6	adult
Valley Group Home	10	adult
Haven Resident Home (women)	8	adult
Haven Resident Home (men)	8	adult

GROUP HOMES (cont'd)	NUMBER OF RESIDENTS	AGES
Waymon Shelton Group Homes	4	adult
Patrick Detwiller Group Home	3	adult
Harry Youngberg Group Home	3	adult
Frank Scully Group Home	3	adult
Orin Baker Group Home	8	adult
Arnie Lee Memorial Group Home	8	adult
Total served	77	

CHILDREN'S GROUP HOMES	NUMBER OF RESIDENTS	AGES
Alvin Bakke Group Home	10	4 thru 21
Total served	10	

RESIDENTIAL ADULT CARE FACILITIES	NUMBER OF RESIDENTS	AGES
Community Living, Inc.	12	adult
Outreach Community Center	146	20 thru 60
Community Involvement Program	32	adult
Total served	190	

STATE INSTITUTIONS	NUMBER OF RESIDENTS	AGES
Cambridge	1,049	5 and up
Brainerd	906	5 and up
Lake Owasso	102	5 and up
Faribault	1,644	5 and up
Fergus Falls	285	5 and up
Hastings	67	5 and up
Minnesota Learning Center	394	5 and up
Minnesota Valley SAC	394	5 and up
Moose Lake	63	5 and up

STATE INSTITUTIONS (cont'd)	NUMBER OF RESIDENTS	AGES
Rochester	99	5 and up
Total served	5,003	

Oak Terrace Nursing Home

Gillette State Hospital for Crippled Children — All have retardates, but primary diagnosis is varied for admittance.

Ah-Gwah-Ching Nursing Home

Those homes specifically for the adult retarded that we know of (which are licensed by the Health Department) are the following.

LICENSED BOARDING CARE HOMES	NUMBER OF RESIDENTS	AGES
Robert Milton	139	Retarded adult
Reaney Heights	113	Retarded adult
Greenbrier Home	175	Retarded adult
Norhaven Home	114	Retarded adult
Ecklund Home	25	Retarded adult
Warner Board and Care Home	30	Retarded adult
Granite Boarding and Care Home	20	Retarded adult
Total served	616	

LICENSED BOARD AND LODGING HOMES	NUMBER OF RESIDENTS	AGES
Ruud Boarding Care Home	38	Retarded adult
Hearthside Home	30	Retarded adult
Pillsbury Manor	7	Retarded adult
Smith Boarding Home	18	Retarded adult
Oscar Johnson Home	6	Retarded adult
Clinton Club	30	Retarded adult
Total served	129	

APPENDIX E

PRIVATE REHABILITATION FACILITIES IN MINNESOTA

Private Rehabilitation Facilities in Minnesota

The following list of 38 private facilities was provided by the Facilities Section of the Division of Vocational Rehabilitation. The 40 facilities listed last year served a total of approximately 9,000 handicapped people. It is not known how many people received which services, how many may have been served by more than one agency, or how many of these 9,000 are developmentally disabled. The list does not include the many private residential programs in day activity centers for the retarded.

Name	Services Provided	Number Served Last Year
Ability Building Center, Rochester	Work evaluation Work adjustment training Sheltered employment Work activity center	170
Anoka-Hennepin Work Adjustment Center, Anoka	Vocational evaluation Work adjustment training	159
Cedar Valley Rehabilitation Workshop, Austin	Vocation evaluation Work evaluation Work adjustment training Sheltered employment	90
Circle F Club, Minneapolis	Social group work and day activity center program	Not available
CWDC Industries, Inc., Virginia	Work evaluation On-the-job training Sheltered employment	66
Cooperative School Rehabilitation Center, Minnetonka	Vocational evaluation Work evaluation Work adjustment training Special education classes	251
Curative Workshop, Minneapolis	Therapy	750

Name	Services Provided	Number Served Last Year
Duluth Goodwi11 Industries, Duluth	Work evaluation Work adjustment training Sheltered employment	97
Duluth Lighthouse for the Blind, Duluth	Work evaluation Work adjustment training Sheltered employment	Not available
Duluth Office Services, Inc., Duluth	Work adjustment training Sheltered employment	Not available
Duluth Sheltered Workshop, Duluth	Vocational evaluation Work evaluation Work adjustment training Sheltered employment Work activity center	125
Interstate Rehabilitation Center, Red Wing	Work evaluation Work adjustment training Sheltered employment	35
Iron Range Rehabilitation Center, Virginia	Therapy	801
Jewish Vocational Workshop, Minneapolis	Work evaluation Work adjustment training Sheltered employment	*49*
Kenny Rehabilitation Institute, Minneapolis	Vocational evaluation Work adjustment training Physical medicine and rehabilitation	133
Lake Region Sheltered Workshop, Fergus Falls	Vocation evaluation Work evaluation Work adjustment training Sheltered emp1oyment	110
Mankato Rehabilitation Center, Mankato	Vocational evaluation Work evaluation Work adjustment training Sheltered employment Work activity center Skill training Occupational therapy Physical therapy Speech	1,097

Name	Services Provided	Number Served Last Year
Midway Learning and Manufacturing, St. Paul	Sheltered employment Work activity center	73
Midwest Special Services, (United Cerebral Palsy) St. Paul	Work evaluation Work adjustment training Sheltered employment	2k
Minneapolis Goodwill Industries, Minneapolis	Vocational evaluation Work evaluation Work adjustment training Sheltered employment	73
Minneapolis Rehabili tation Center, Minneapolis	Vocational evaluation Work adjustment training	872
Minneapolis Society for the Blind, Minneapolis	Vocational evaluation Work evaluation Work adjustment training Sheltered employment	Not available
Minnesota Academy of Seizure rehabilitation, Minneapolis	Vocational evaluation Work adjustment training Work activity center Medical	67
Minnesota Homecrafters, Minneapolis	Work evaluation On-the-job training Provides craft training and sales of handicraft products for home bound persons	100
Northwestern Minnesota Sheltered Workshop, Thief River Falls	On-the-job training Sheltered employment	New program
Occupational Training Center, St. Paul	Vocational evaluation Work adjustment training Sheltered employment Skill training	298
Opportunity Training Center, St. Cloud	Work adjustment training Sheltered employment	30
Opportunity Workshop, Minneapolis	Work evaluation Work adjustment training Sheltered employment Work activity center Skill training	421

Name	Services Provided	Number Served Last Year
Outreach Community Center, Minneapolis	Residential programs for retarded	216
Nat. G. Polinsky Rehabilitation Center, Duluth	Therapy	1,214
RISE Incorporated, Spring Lake Park	On the job training Sheltered employment	New Program
St. Paul Goodwill Industries, St. Paul	Vocational evaluation Work evaluation Work adjustment training Sheltered employment	348
St. Paul Rehabilitation Center, St. Paul	Vocational evaluation Work evaluation Work adjustment training Sheltered employment Occupational therapy Physical therapy Speech	1,068
St. Paul Society for the Blind, St. Paul	Vocational evaluation Work evaluation Work adjustment training Sheltered employment Skill training	28
School for Social Development, Minneapolis	Work evaluation Work adjustment training Work activity center Sheltered employment	40
The Achievement Center, Worthington	Work adjustment training Sheltered employment	27
United Cerebral Palsy of Minneapolis, Minneapolis	Work evaluation Work adjustment training Sheltered employment	179
West Central Industries, Willmar	Work evaluation Work adjustment training Sheltered employment	87